NGO FORUM FOR HEALTH

VIOLENCE AND HEALTH

Proceedings of a Symposium

Geneva, Switzerland

Palais des Nations

14 May 2001

Dr. Eric Ram, President
Dr. Elizabeth L. Bowen, Rapporteur
Ms. Gauri Khanna-Reidhead, Dr. Elizabeth L Bowen, Editors

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REPORT OF THE NGO FORUM FOR HEALTH
Violence and Health
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MESSAGE FROM THE PRESIDENT

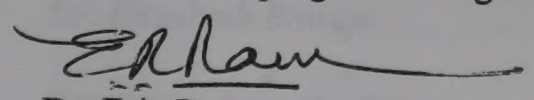
I deem it a privilege to present this report which summarises the proceedings from the Annual General Meeting and the Symposium, jointly sponsored by NGO Forum for Health and WHO. The theme for this year's meeting was VIOLENCE AND HEALTH, and was held at the Palais de Nations in Geneva on 14 May 2001. I wish to express my deep gratitude to all our speakers – Dr. Etienne Krug, Prof. Peter Newell, Ms. Jane Cottingham, Dr. Mireille Kingma, Ms. Berhane Ras-Work, Mr. Hans Rüttiman and Dr. Elizabeth Bowen for their time and dedication in preparing and presenting excellent papers and contributing so richly to the programme. My thanks also go to those who added to the value of the symposium by making comments from the floor and sharing their own experiences.

Additionally, I do want to say a big "thank you" to Dr. Beth Bowen of Health for Humanity, our conference rapporteur, who for the fifth consecutive year has assumed this important role. And to Ms. Gauri Khanna Reidhead, the editor, who along with Beth has put this excellent report in record time, a tribute to their efficiency and dedication to producing professional results.

The symposium brought together a group of experts from around the world who shared information on various aspects of violence, how they affect health and what we as NGOs can do to prevent them. All the presentations are included in the report. Additionally, we have also included the comments from the floor, because the participants shared their own experience from the field, thus adding value to the discussion of the theme.

This report also contains, for records, the proceedings of the Business Session including Dr. Manoj Kurian's (treasurer's) report for the FY2000, which shows that we have a good financial status. A small executive summary of the progress report on Global Health Watch, as presented by Ms. Asmita Naik, is included. A printed copy of the report is available through the office of the President of the Forum.

It is my hope and prayer that you will find this year's report both useful and inspiring in taking up the huge challenge of stopping, preventing and infact, reversing the epidemic of violence sweeping over the globe.



Dr. Eric Ram
President

NGO FORUM FOR HEALTH

— partnering to make health a reality —
— promoting equity and justice in health care —

Benefactor: *Life University - Georgia, USA*
Founding Members: *World Vision International, Geneva; World Council of Churches, Geneva*

Annual General Meeting and Symposia

Palais des Nations, Geneva - Room XXII

Monday, May 14, 2001, 13:30 hrs to 18:00 hrs

SYMPOSIUM I

VIOLENCE AND HEALTH

Chair: Dr. Eric Ram

Agenda

13:30 - 14:00	Opening and Welcome Dr. Eric Ram, World Vision International
Panel I	
14:00 - 14:30	Health and Violence: A Global Perspective Dr. Etienne Krug, World Health Organisation
14:30 - 15:00	Combating Violence Involving Children Prof. Peter Newell, UK
15:00 - 15:30	Consequences of Violence on Women's Health Ms. Jane Cottingham, World Health Organisation
15:30 - 16:00	Violence Against Health Care Providers Dr. Mireille Kingma, International Council of Nurses
16:00 - 16: 15	*Tea Break*
Panel II	
16:15 - 16:30	Traditional Violence Against Girls Ms. Berhane Ras-Work, Inter African Committee
16:30 – 16:45	Alcohol and Violence Mr. Hans Rüttimann, International Federation of the Blue Cross
16:45 – 17:00	Overcoming the Violence of Silence Dr. Elizabeth Bowen, Health for Humanity
Business Section	
17:00 – 18:00	• Chairman's Report - Dr. Eric Ram • Treasurer's Report - Dr. Manoj Kurian • Elections of Office Bearers – TBD • Global Health Watch Update - Ms Asmita Naik
18:00	Close

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VIOLENCE AND HEALTH

Dr. Eric Ram
President, NGO Forum for Health

Welcome and Introduction

Friends, Ladies and Gentlemen,

It is a great pleasure for me to welcome you to our Annual General Meeting as well as the Symposium today. These events are designed to coincide with the World Health Assembly each year to allow greater participation of the NGOs in the WHA as well as dialogue between government delegates and NGOs on specific issues and topics.

I wish to extend a very warm welcome to all of you who have traveled long distances for these events, in particular, our speakers who have graciously accepted our invitation and come to Geneva to share with us their knowledge, experiences and vision for the future. Thanks.

I wish to thank Dr. Roberta Ritson and Dr. John Martin of WHO, who serve on the Steering Committee of the Forum, for organizing and getting us this hall for our meetings. Also to Jocelyn Matsumoto for security clearance. Let me also express my thanks to Dr. Elizabeth Bowen who for the last 5 years has diligently served us as the rapporteur. Thanks.

This is your Forum and I want you to feel at home here, participate freely and contribute liberally to the richness of the discussions, remain open and take back home something with you which your organization can use in the promotion of greater equity and justice in health care around the world.

You are in for a great treat today, as we will get to hear from all our world-class speakers, who have especially come for this symposium today. I will introduce them to you when their time to speak comes later on.

The Two Symposia

This year we are going to have two symposia. The theme for the first symposium today is: **Violence and Health**.

And, the theme for the second symposium which will be held tomorrow is: **Low Back Pain and Spinal Hygiene**. Both these symposia are organized jointly by WHO, Life University and NGO Forum for Health.

Today's programme is divided into two parts. First we have the symposium comprising of two panels followed by the business session, for which the paying members of the Forum are invited to stay and participate.

If you are not a member but would like to become one, then please contact Ms. Gauri Khanna-Reidhead, and pay the membership fee, which will give you the right to vote beginning today.

Violence and Health

In the recent years we have witnessed a dramatic increase in the new cases of intentional injuries worldwide, affecting men, women and children, of all ages and socio economic backgrounds. Today's
wars, armed conflicts and related violence have devastating effects on civilians, especially women and children undermining their social, economic, physical, mental and spiritual health.

Indeed, violence has become a major public health problem worldwide, resulting in deaths due to injuries of over two million each year. Violence is also violation of human rights, as it undermines health and human life. Unfortunately, violence against women and children, rape and sexual assaults are on the increase. It is estimated that 20% of female population in the world has been physically or sexually assaulted by men in their life. Psychological and emotional abuse such as constant belittling, intimidation and humiliating treatment, put women at increased risk of depression, suicide attempt, chronic pain syndrome and psychosomatic disorders. Violence has nothing but negative effect on health. In addition to injuries and death, violence can also result in deep psycho-social health problems, depression, HIV and other sexually transmitted diseases, unwanted pregnancies, sleeping and eating disorders, fear related anxiety, etc.

Health care providers, especially nurses, too become victims of violence in work places. In domestic violence, especially gender-based violence, women are generally the targets. Rape within and outside marriage, especially during conflicts, as a weapon of war, trafficking of women for prostitution, female genital mutilation and female infanticide, are geared against young girls and women.

Unfortunately, societal tolerance and cultural tolerance of such abuses, does not help us in our fight against domestic and family violence. Yet, violence is preventable. Even violent behaviours need to and must be changed. Bullying in the schools is a common phenomenon.

Youth and adolescents both as victims and perpetrators of violence is a big concern. The involvement of children as combatants in armed conflicts exposes them to many health risks, injuries and death.

Then there are self-directed violence. Over one million deaths due to suicide were reported in Year 2000. This is a growing problem among the youth, particularly in Europe.

All these have direct or indirect impact on health of the individuals, communities and the nations.

The intentional use of force against other people or one-self that results in injury, death or one that does psychological harm, must be prevented, causes analyzed and sources of the problem

eliminated. In many cases that would mean going down to the very fabric of our society. The World Summit for Social Development in Copenhagen (1995) recognized this and committed to introduce and implement specific policies and programmes of public health and social services to prevent violence in society and mitigate its effect.

International Conference on Population and Development (Cairo, 1994) and Fourth World Conference on Women (Beijing, 1995) declared that violence against women and girls is problem with health consequences and must be tackled urgently.
Poverty is one of the key underlying factors in violence, the sense of frustration, insecurity, deprivation, and belittlement the poor people experience due to inequities in life.

Violence as a public health problem is a big and complex issue and will require a coordinated effort by the governments, NGOs and intergovernmental organizations like WHO and UNICEF to tackle this issue. Violence has many dimensions and the approach, therefore, has to be multifaceted. We need to promote and support movements and campaigns for peace and against violence, armed conflicts, recruitment and use of child soldiers under 18 years of age. We need to make our home and work places safer and free of violence. We must work to make our communities, nations and indeed the world violence and conflict free.

We are very fortunate to have world class speakers today who would share their perspectives and their vision as to how to deal with violence as a public health issue.

VIOLENCE: DEEP ROOTS, BROKEN BRANCHES

Dr. Etienne Krug

Good afternoon,

Over the years, we have all been exposed daily to the terrible images of human misery caused by deadly conflicts in the Middle East, Kosovo, East Timor, Sierra Leone or the Democratic Republic of Congo, to name only a few. The mass graves, mass rapes, and massive exodus are the most visible part of the iceberg of violence. More discrete, but even more widespread, is the daily suffering of children who are abused by their care givers, women who are victims of violent partners, elderly persons maltreated by their children, or students who cannot attend school without being at risk of being threatened, beaten or shot.

Despite the grief, the sadness, the outrage we all feel about it, violence has strangely enough long been passively accepted as a tragic, but inevitable part of life. That is changing. During the past few years, public health is increasingly taking a stand against accepting violence as an inevitable part of our modern world and is taking actions to reduce it.

There is no need for me to tell you more about the tragedy, grief and rage that violence causes. Instead, I will focus on violence as a global public health issue. I will give you some figures that can better help us place it in perspective, I will briefly outline some of the factors that contribute to causing violence and describe some of the lessons we learned in trying to prevent violence.

The Public Health Approach to Violence

Traditionally, violence has been seen as predominantly a legal issue. Only during the last decades has violence been increasingly recognised as a public health problem in a few countries. In most of the world, violence prevention is still absent from the public health agendas.

Yet, a public health approach can add considerable value. It is interdisciplinary, science-based, and focused on prevention.

Interdisciplinary, because public health is at the intersection of medicine, epidemiology, sociology, criminology and several other fields. Bringing together the strengths and approaches of each of these fields, allows public health to be innovative.

Science-based because interventions are based on the diligent study of risk and protective factors. Interventions are evaluated before being implemented on a wider scale.

Focused on prevention, because we believe that it is important to anticipate, to act early in order to avoid young men and women becoming violent. We believe that by implementing the appropriate interventions at an early age we can avoid that many potential perpetrators enter a downward spiral of violence that will end up destroying their lives as well as those of their victims, their families and in some cases their communities.

I will argue that it is the focus on prevention that is the main strength of the public health approach to violence. Both primary prevention, which focuses on avoiding violence altogether and secondary prevention which aims at reducing its consequences. In contrast to the more traditional judicial approach that is mainly based on punishment of the perpetrators once the violence has taken place, public health believes that by addressing its social, economic or other causes, a considerable proportion of violence will be prevented.

What is Violence?

Before I continue, let us clarify what we are talking about.

Violence has been defined in many ways. The definition commonly used by the World Health Organization is that violence is "the intentional use of physical force or power, threatened or actual, against another person or against oneself or against a group of people, that results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation."

While there is no universally accepted typology for violence, the groupings most commonly used are: interpersonal, self-inflicted and organised violence. Each of the above groups can in turn be divided into more specific areas such as child abuse, intimate partner abuse, elderly abuse, youth violence, sexual violence, etc. (Fig. Typology of Violence))

It is useful to subdivide violence into these different subtypes to be able to study specific risk factors or trends.

However, whatever the typology used, it is also important to keep in mind that there are many links between each of these types of violence: E.g. Victimisation of assault or abuse has been associated with a higher risk of suicide; Victimisation of child abuse has been described as a risk factor for subsequent violent behaviour; Exposure to intimate partner violence is a risk factor for future violent behaviour; and variables used to measure the social acceptability of violence, such as the death penalty or the involvement, have been associated with the homicide rate in a society.

This is important: reducing one type of violence may also contribute to decreasing levels of other types of violence.

The Global Burden

How big a problem are we really talking about? In public health terms, it is substantial.

In the beginning of our 3rd millennium, 4% of all persons who die in the world are intentionally killed by another person or by themselves.

In 1998, an estimated 2.3 million people died from violence – just under the number of those who died that year from HIV/AIDS, which we now recognize as a global emergency. 42% of these deaths were classified as suicide, 32% as homicide and 26% as war-related. World wide the homicide rate is 12,2 per 100,000 population. There are considerable regional differences in the relative importance of these type of deaths: E.g. In China, there are 7 suicides for each homicide. However in Sub Saharan Africa and in Latin America and the Caribbean there are respectively 13 and 5 homicides for each suicide (Fig. Estimated Homicide Rates by Region, 1998).

Like for many other health problems, violence is not distributed evenly among income groups. The homicide rate for countries in the low and middle income group is estimated to be 3 times higher than the homicide rate in countries from the high income group (13.6 compared to 4.3). The homicide rate in Africa (48.8/100 000) is 11 times higher than the homicide rate in high income countries.

What is also important to notice is that in addition to death and injury, victimisation of violence also causes a large number of other health consequences. Victimisation by family or intimate partner violence can, for example, lead to depression, suicidal behaviour, eating disorders, smoking, or alcohol or drug use. In addition to these health consequences, victims of sexual violence can also suffer from unwanted pregnancy or sexually transmitted diseases. Populations exposed to political violence or conflict often suffer malnutrition or from increases in infectious diseases (Fig. Health Consequences of Violence).

WHO estimated that annually 40 million children are suffering from child abuse world wide. Studies focusing on sexual abuse of children have been conducted in many countries and have shown clearly that the problem crosses boundaries and cultures. The methodological and definitional differences in the way most studies are conducted means it is often difficult to compare data from different countries. Yet, estimates of sexual abuse compiled from 20 countries from 4 continents, ranged from 7% to 36% for girls and 3% to 29% for boys.

Studies conducted around the world, lead us to the same conclusion, showing the universality of violence against women. Results from a sample of studies with similar epidemiological characteristics and representing countries from all continents and income groups, showed that depending on the country, from 5% to 67% of women interviewed, reported having been physically abused by an intimate partner during their lifetime. The percent of women who reported having suffered from attempted or completed rape by an intimate partner ranged from 6% to 48.5%.

Because interpersonal violence is such an important and often forgotten health problem, and because I believe that that is an area where public health has a particularly important contribution to make, I'll focus, for the rest of my talk, mainly on this topic.

How and Why Does Violence Occur?

Violence is a multifaceted and complex problem. No single factor explains why some individuals behave violently toward others or why violence is more prevalent in some communities and not others. Violence can be explained as the product of factors at four levels of influence that are often represented as concentric circles: the individual level, the level of proximal relationships, the community context and the larger societal factors.

> Individual level factors which increase the likelihood of perpetration of violence include impulsivity, low educational attainment, alcohol abuse, and a history of having been abused during childhood. Although the data is still inconclusive on this topic, repeated exposure to high levels of media violence may also be a risk factor for some individuals.
>
> Factors related to close social relationships (e.g., with peers or family members) include for example, peer pressure which is a risk factor for youth interpersonal violence and lack of parental skills, a risk factor for child abuse. Male control of decision making is an important factor contributing to violence against women in the home.
>
> At the third level we find factors related to community contexts. Low community cohesion, isolation of women and physical deterioration of infrastructure have been identified as important factors contributing at that level.
>
> Finally, we have the larger societal factors that influence violence. They include, for example, norms that encourage male dominance over women, cultural norms that support violence as an acceptable way to resolve conflict, social policies that sustain gaps between the rich and poor, norms that support police use of excessive force over citizens, or norms that ease access to guns.

It is important to note that while some risk factors may be unique to a particular type of violence, more often the various types of violence share a number of risk factors. Prevailing cultural norms, poverty, social isolation, and such factors as alcohol consumption, substance abuse, and access to firearms are risk factors for more than one type of violence. As a result, it is not unusual for some individuals at risk for violence to experience more than one type of violence. Women at risk for physical violence by intimate partners, for example, are also at risk for sexual violence.

Identifying the factors that increase or reduce the risk for violent victimization and perpetration at the different levels is an important step toward preventing violence. Once these factors are identified, we can begin to develop interventions or prevention programs aimed at reducing or modifying the risk for violence.

Preventing Violence

Despite the staggering statistics, the data also shows that violence is preventable and should not be considered as an inevitable part of society. For example, why does Switzerland, which contains three indigenous language groups, an immigrant population that has reached 20% of the population and the highest density of guns in the world have a 500 year history of peace, while the neighbouring former Yugoslavia has such a different past? Why is the homicide rate in Japan 0.6 per 100,000 people while in the U.S. it is 7 per 100,000 and in Estonia 25 per 100,000? Why are the firearm death rates in Asia almost 100 times lower than in the Americas?

We need to take the time to learn from these important cross-cultural differences. Some differences are obvious, some are complex. Some lessons are transferable to other countries, some are not. But in all, there is enormous potential here to gain knowledge which can prevent further unnecessary premature deaths through the development of sound interventions and policies.

Research has allowed us to establish some principles for interventions for violence prevention. At this stage most of the research has been conducted in Western societies and little is known about the universality of these principles. What is certain however, is that there are no easy remedies. Violence is a complex issue with complex causes and only a number of interventions implemented at the same time at different levels will allow for notable improvements.

Another lesson is that interventions need to occur at early stages. To be efficient, interventions need to target children as early as possible and before adolescence. Even behaviours that occur during adolescence, like school violence, or even adulthood, such as child or intimate partner abuse, need to be prevented by intervening during childhood.

As discussed, interventions have to be conducted at different levels: the individual, the family, peer groups or the larger community. Examples of interventions that target the individual are programmes that focus on anger management or self-control. These interventions aim at changing an individual's attitudes and beliefs. Family level interventions focus on improving the way parents supervise and discipline their children. Training programmes for parents or home visitation programmes are used to prevent child abuse. Programmes that focus on changing group interactions are often peer mediation programmes. In these programmes, youth are assisting other youth by mediating conflicts or serving as positive role models. At the community level, interventions focusing on improving neighbourhoods or school settings can be undertaken. These interventions can target the physical environment (e.g. increase lightning), improve school security (metal detectors) or also focus on behavioural changes such as anti violence awareness campaigns.

In addition to these primary prevention efforts, secondary prevention efforts are needed to reduce the long term impact of violence on victims and their families. Adequate emergency referral systems and pre-hospital and hospital care are needed for the treatment of injuries. In many parts of the world, this is still a problem. For example, it is estimated that 2/3 of landmine victims die because of lack of appropriate emergency response system. Psychological support also needs to

be given to victims of the different types of violence. For example, support groups are often very helpful for victims of intimate partner violence or sexual abuse.

Another very important lesson that we have learned is the need for a multi-disciplinary approach. No sector or discipline will be able to tackle the problem of violence alone. It is only by joining forces between police, social workers, public health professionals, teachers, human rights advocates and others that we will be able to make a real difference. For example, as discussed earlier, sex discrimination and gender roles are contributing factors to violence against women. Modifying laws and policies in light of the fundamental human rights principle - freedom from discrimination - could go a long way. Every country in the world has now ratified at least one human rights instrument and the public health community should seize the opportunity of using human rights as an additional tool for violence prevention.

A World Report on Violence and Health

During recent years, some important developments have taken place in the international arena. In view of what it described as a dramatic increase in the incidence of intentional injuries, the Forty-Ninth World Health Assembly adopted resolution WHA 49.25 in 1996, declaring violence a leading world-wide public health problem. The Resolution urged Member States to assess and develop science-based solutions to the problem. Following that, a number of activities were initiated by WHO and its partners, particularly in the area of data collection, prevention and advocacy. And it is only a few months ago, that the WHO Director General, Dr Gro Harlem Brundtland, decided to create a department devoted specifically to the issue of violence and injuries prevention.

This WHO Department for Violence and Injury Prevention is building activities based on the WHA resolution. Our first priority is to get the data straight. We are gathering all available data from around the world and mapping out where there are large gaps in knowledge.

In collaboration with several centres and experts from around the world, WHO is producing the World Report on Violence and Health. The goals of this document are to raise world-wide awareness about the public health aspects of violence and to highlight the contributions of public health to understanding and responding to the problem of violence. We hope that, after its release in 2002, it will become a tool for Ministries of Health, Interior and Justice, NGOs and other relevant professionals to initiate prevention activities all around the world.

Other activities being planned by this new programme include the development of a frame work and guidelines to facilitate action at country level, as well as an upcoming meeting for all UN agencies in which we will share experiences in the area of violence prevention and work towards developing a common agenda.

From the blood-stained walls of the churches in Rwanda to the black and blue face of a battered child: violence tend to be overwhelming for those who witness it and must try to stop it. Where do we start, when each single blow, each bullet fired, is such an appalling offence to health, to dignity, to life? There are of course no easy answers. But I hope, and strongly believe, that violence can be prevented. It is complex and difficult. It doesn't hold the news appeal of trials

and prisons. But those who are involved know that there is no better feeling than to know one has contributed to preventing a child or a woman from being beaten, or a youth from destroying his and others' lives.

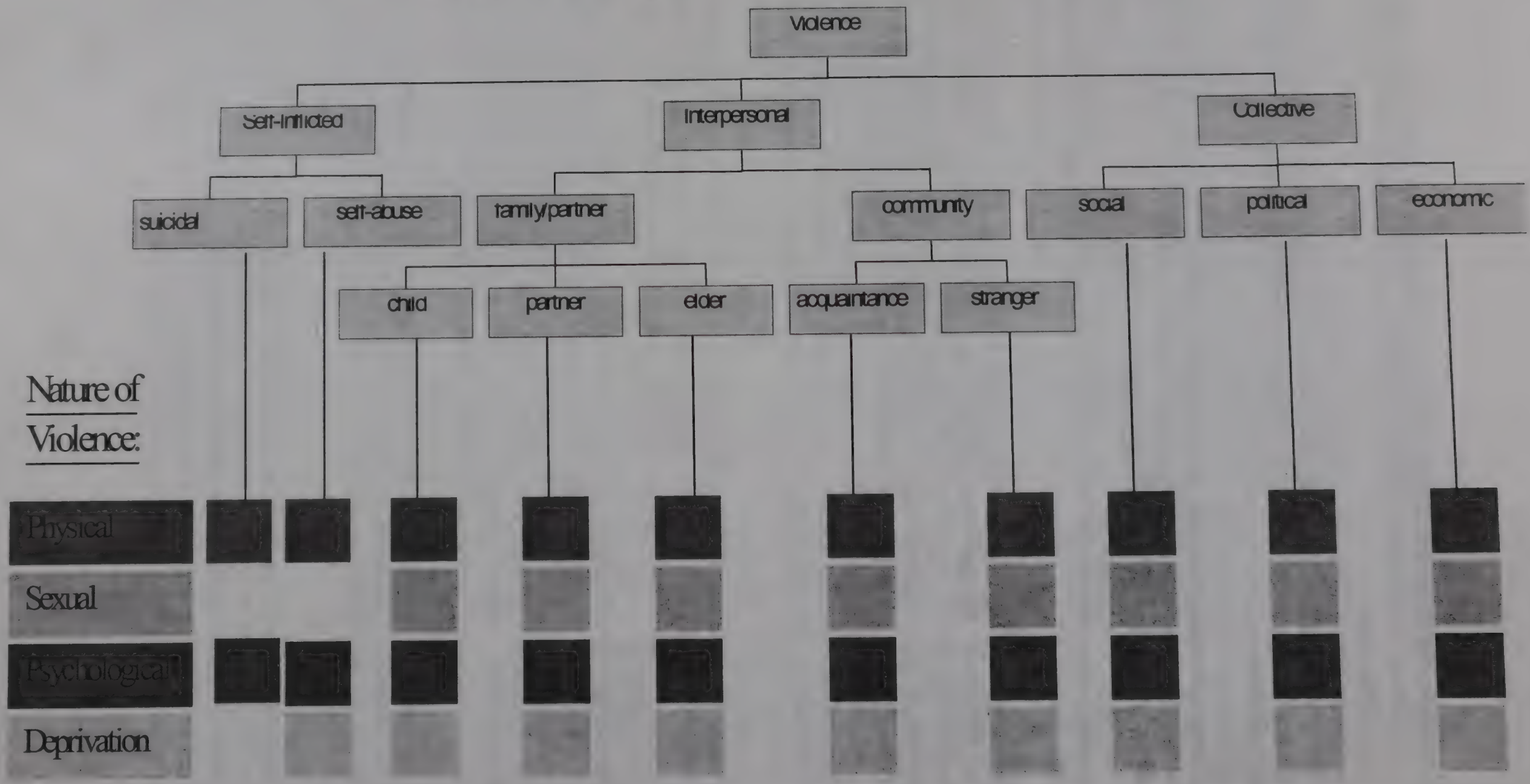
A few years ago, the US Centers for Disease Control published a study on international gun violence. This prompted a 12 year old boy to write the following lines to Dr D Satcher, then CDC's Director.

"...Twenty years ago what kids worried about was getting bad grades. But now, kids are worried about getting killed...I'm scared too and I don't want to die. I have a whole lot of life to go and make my own goals and be what I want to be..."

In a world, where kids live in fear of getting killed, something has gone terribly wrong. It is time to act.

Thank you.

Typology of violence



World Health Organization

Health consequences of violence

Violence

Fatal Outcomes

- **Homicide**
- **Suicide**
- **Maternal Mort.**
- **AIDS**

Non Fatal Outcomes

- **Injury, disability**
- **Mental health**
- **Behavioural**
- **Functional**
- **Reproductive**

Cost for Health Systems

Estimated homicide rates, by region, 1998

World Health Organization

COMBATING VIOLENCE INVOLVING CHILDREN

Prof. Peter Newell

Introduction

Violence against children is a pervasive world problem of huge dimensions. No state can feel complacent about its protection of children from violence. The definition of violence I will use is that adopted by various commissions on violence around the world: "Violence" is defined as behaviour by people against people liable to cause physical or psychological harm. There are other societal forms of violence – poverty above all, exploitative child labour, and non-deliberate neglect by the state, parents and others. But my focus will be on inter-personal violence. And while the title I have been given is "Combating violence *involving* children", I shall talk mostly about violence perpetrated against children, rather than by them; there is ample evidence that most violence by children is rooted in the experience of adult violence against them. "Children" is defined as in the Convention on the Rights of the Child as everyone from birth to 18.

"The history of childhood is a nightmare from which we have only recently begun to awaken" – thus American historian Lloyd de Mause began his celebrated anthology almost 30 years ago. Unfortunately, what we do know now about levels of violence to children suggests that an awful lot still remains hidden, in particular within families, that most societies' toleration of violence to children remains very high, and that adults are constantly inventing new forms of violence and exploitation of children.

What has changed is that we do now have an almost universally adopted human rights imperative for protecting children from all forms of violence. The Convention on the Rights of the Child now provides the obvious framework for moving to prevent violence against children. Under the Convention, states take on obligations under international law to protect children from "all forms of physical and mental violence" while in the care of parents and others; other articles bar torture and cruel, inhuman or degrading treatment, require abolition of harmful traditional practices, sexual abuse and exploitation, sale and trafficking and protection of children in the context of armed conflict. Violence to children challenges the fundamental human rights to respect for human dignity and physical integrity. The existence of laws that tolerate violence to children – "reasonable chastisement", "lawful correction" and so on violates the right to equal protection under the law.

Violence Against Children

The Committee on the Rights of the Child, Treaty Body responsible for monitoring implementation of the Convention, in its report to next September's UN General Assembly Special Session on Children, refers to "the widespread practice of violence against children. It

takes many forms and different levels of intensity. If the Committee puts its information together a very horrific and disturbing picture appears.... This picture constitutes numerous violations of most children's rights and illustrates how far the world is from respecting children as human beings with rights".

Another snapshot of the level of violence against children is provided by a mammoth poll conducted earlier this year on behalf of UNICEF across 35 countries in Europe and Central Asia (*Young Voices*, May 2001, UNICEF). Representative of the views and experiences of over 94 million children aged 9 to 17, it found six out of 10 overall reporting that they face violent or aggressive behaviour in their homes. One in six children reported feeling unsafe walking around their immediate neighbourhood.

The Committee on the Rights of the Child has proposed to the UN a comprehensive study of the nature, causes and ways to prevent violence to children, along the lines of Graca Machel's study of children in armed conflict (and in terms of combating violence to children this is a recommendation we should strongly support.)

Forms of Violence

Violence to children, like violence to women, is rooted in traditional concepts of ownership, of children as objects, chattels, not individual human beings and holders of human rights. So challenging all violence to children is not just about protecting them from injury or harm: it is of key importance to the status of children, to the realization of all their rights.

Some like to make a distinction between state and private violence to children. But that is both artificial and dangerous. The state is responsible under international law for protecting all children without discrimination from all forms of violence. The state is responsible for the law and its enforcement, for deterring and preventing violence, whether the perpetrator is a state official or a parent.

Outside areas of intense armed conflict, children are undoubtedly more at risk of violence from those closest to them, within their families, schools and other institutions than they are from strangers (just one example, of 289 homicides of children under 18 in a recent two year period in the UK, only13 per cent were killed by strangers; 60 per cent by parents).

There are some statistics which I have found shock people to the point of disbelief: for example, the fact that infants under the age of one are at four times greater risk of homicide – almost invariably by a parent – than any other age group (this is true of the UK and of some other industrialized countries where analysis exists). One significant indication that this is an issue about the status of children is the existence in many legal systems of the special crime of infanticide, defined as a lesser crime than murder. Of course there may be special reasons for killing infants, and special defences, like that of diminished responsibility, need to be available as they are for other murders. But the roots of the special status of this crime lie in regarding the life of an infant as of less worth than that of an older person.

Adults undoubtedly feel easier talking about extreme forms of violence to children, the sort of violence that "other people" perpetrate. Thus, for example, there has been a far louder international call for action on the threat posed by commercial sexual exploitation and in some countries including mine on the threat of paedophiles in the community than on the very high prevalence of sexual abuse within the family; a greater focus on violence and murder of

street children in certain countries than on the cumulatively huge numbers of children who are murdered horribly by their parents (and in parentheses, we know that very many children – probably the majority – are on the streets because of their experience of violence in their homes).

I am not of course suggesting at all that the increased awareness of commercial sexual exploitation and the emergence of special laws and policies to prevent it is in any sense unproductive. But if we are to make real progress in challenging violence to children, we do have to move beyond issues on which there is already a consensus and work on those which remain controversial because they challenge traditional attitudes to children, because they are nearer to the personal lives and experiences as children and parents of the majority of people.

Campaigning Against Corporal Punishment

One large part of my work has been campaigning against corporal punishment of children, both in the UK and internationally. The Committee on the Rights of the Child has put the issue prominently on the international agenda by consistently stating that continued legal and social approval of any corporal punishment is incompatible with the Convention, and recommending that states should abolish it and implement public education campaigns to promote positive, non-violent discipline.

Last month in Geneva Thomas Hammarberg, Sweden's Ambassador for Humanitarian Affairs, and I launched a new Global Initiative to End All Corporal Punishment of Children (www.endcorporalpunishment.org) which has the support of UNICEF and members of the Committee on the Rights of the Child. The High Commissioner for Human Rights, Mary Robinson, has made a strong supportive statement, emphasising the significance of this issue for children.

"The recourse to physical punishment by adults reflects a denial of the recognition, by the Convention on the Rights of the Child, of the child as a subject of human rights. If we want to remain faithful to the spirit of the Convention, strongly based on the dignity of the child as a full-fledged bearer of rights, then any act of violence against him or her must be banned, in accordance with articles 19 and 28.2 of the Convention.

"I believe that in addition to legal prohibition, sensitization of all actors of society - in particular parents and teachers - to the negative impact of physical violence is a key aspect of the process leading to a non-violent society. Violence should never be legitimized.

"Physical punishment denies children their fundamental right to grow-up to become capable of making a responsible contribution to a free society. Children and adolescents deserve better than to be beaten for their so-called errors or disobedience. They deserve constant and quality guidance and attention; creative and enriching dialogue; and stimulating and challenging education. No form of violence, including physical, sexual or psychological, can ever be justified as being in the best interests of
the child."

Corporal punishment, violence justified by its perpetrators as "discipline", causes death, serious injury and disability to many children in all continents. In fact, in very many cases if similar violence was perpetrated against an adult it would be described as torture. Outside areas of intense armed conflict, it is certainly the most common form of violence experienced

directly by children in most countries. In the last decade it has begun to become visible through interview research with parents, and more rarely with children. For example:

- **Barbados**: 70 per cent of parents "generally approved" of corporal punishment and of these 76 per cent endorsed beating children with belts or straps.

- **Chile**: a 1995 survey found 80 per cent of state school parents and 57 per cent of private school parents admitting using physical punishment.

- **Egypt**: large-scale 1996 survey of children found over a third were disciplined by beating - often with straps or sticks; a quarter of these children reported that discipline led to injuries.

- **India**: a survey of university students found that 91 per cent of males and 86 per cent of females had been physically punished in their childhood.

- **Korea**: survey by Child Protection Association found that 97 per cent of children had been physically punished, many severely.

- **Kuwait**: a 1996 survey of parents' attitudes found 54 per cent agreeing, or strongly agreeing, with severe beating in cases of gross misbehaviour. 9 per cent of parents agreed with burning as a form of punishment.

- **Pakistan**: a study covering parents and teachers at 600 primary schools in the North West Frontier Province in 1998 found over 70 reports of serious injury arising from corporal punishment; the most common forms of punishment were beating with sticks, pulling ears, slapping faces and forcing children to stay in humiliating positions.

- **Romania**: 1992 survey found 84 per cent of parents regarded spanking as "normal" method of childrearing. 96 per cent did not consider it humiliating.

- **UK**: Government-commissioned research in the 1990s found that three quarters of a large sample of mothers admitted to smacking their baby before the age of one. In families with children aged one, four, seven and 11where both parents were interviewed, over a third of all the children - 35 per cent - were hit weekly or more often by either or both parents, and a fifth of these children had been hit with an implement.

- **USA**: 89 per cent of a large sample of parents had hit their 3 year-old child in the previous year; about a third of 15 - 17 year-olds had been hit.

The scale is quite horrific – but more horrific is the fact that this is, in general, socially approved and legal violence to children.

So – how do we begin to combat violence to children: there is obviously no time to set out a detailed agenda here. I tried to do so in a UNICEF Innocenti Centre publication a few years ago (*Children and Violence*, Innocenti Digest no. 2, UNICEF International Child Development Centre, Florence, 1997). Our overall aim is to build safe, non-violent societies for all. We focus on children because there is substantial evidence that early interventions can

prevent the development of violent attitudes and actions: the most likely way to immunise children against becoming violent is to protect them from violence and violent attitudes in their early years.

What do we need now?

Increased visibility

- Increased visibility of all forms of violence to children in all settings: internationally perhaps through the proposed UN Study of Violence against Children. Hopefully the forthcoming (September 2001) UN General Assembly Special Session on Children will provide some specific goals to make violence visible and reduce it over the coming decade. There is also a proposal for a new Special Rapporteur on Violence Against Children, but we need to make the most of existing structures and in particular the reporting process under the CRC. As many of you will know the Committee is holding its second day of General Discussion on Violence against Children on September 28, focusing this year on violence in the home and schools. At national level, in every state we need the collection and dissemination of available information and some new studies, including in-depth interviews with parents and with children;

Law reform

- Law reform to ensure that all violence to children is prohibited and that any existing legal defences justifying violence to children are removed (at least 10 countries have taken this step and others are considering it). Children must have effective remedies if the state fails to protect them effectively from violence, and deter violence to them (in the European context, there was a highly significant judgment from the European Court of Human Rights – Z and Others v the UK, May 10 2001 - which emphasises that states must have effective child protection systems accountable to children;

Increased commitment to non-violence in all forms

- Adoption of a loud commitment to non-violence from political and community leaders and NGOs and professional groups;
- Development of coordinated inter-sectoral and interdisciplinary structures focused on preventing violence against children. The health sector obviously has a huge role here;
- Reviewing all forms of support for families and services for children from a specifically anti-violence perspective: what more can all these services do to contribute directly to violence prevention – for example, promoting positive, non-violent forms of discipline in families, alternative care and schools;

Role of the media

- Reviewing the role of the media to develop its contribution to violence prevention and to aim to ensure that the portrayal of violent images does not contribute to the problem of violence involving children

In all that we do to reduce and prevent violence to children we must be wary of unintended effects. To take just one example, already in some countries unrealistic fears of "stranger danger" have led to a serious reduction in children's rights to mobility, to roam and play freely in their neighbourhoods.

You would think that we know enough about violence to children now to be shamed into much greater and more comprehensive action – internationally, nationally, and at a personal, individual level - to end it. The imperative is one of human rights: the rights of children, like the rest of us, to respect for their human dignity and physical integrity and to equal protection under the law. Violence, as WHO has recognised, is also public health issue and if we want to build non-violent societies, the priority focus must logically be on children. The health sector, taking a rights-based approach, has a huge contribution to make.

CONSEQUENCES OF VIOLENCE ON WOMEN'S HEALTH

By Dr. Claudia Garica-Moreno
Presented by Ms. Jane Cottingham

Problem statement

Violence against women (VAW) occurs in many forms and in all places - at home, in the workplace and in the community. Numerous studies have shown that the most pervasive form of gender-based violence is abuse of women by their intimate male partners, either past or present. This is known as domestic violence against women(DVAW) or intimate partner violence (IPV). Reliable studies from countries worldwide over indicate that from 10 to over 50% of women report having been physically abused by an intimate male partner at some point in their lives. Rape and other forms of sexually coercive relationships are also widely prevalent.

Violence against women has serious consequences on women's mental and physical health, including their reproductive and sexual health. These include injuries, gynaecological problems, temporary or permanent disabilities, depression and suicide, amongst others. Because much of this violence is hidden inside the home, it is difficult to document and even harder to prevent.

As the Beijing Platform for Action makes clear (see insert), there is a need for a stronger evidence-base regarding the magnitude and the nature of the problem, in particular the identification of risk and protective factors in different cultural contexts. There is also a need to understand and measure the health consequences of VAW and the synergies between them, in order to assess the real 'burden of disease' related to VAW. Moreover, there is a need for information on interventions that are effective, feasible and sustainable in resource poor settings.

Apart from the fact that VAW is widely under reported, police and judicial systems often refuse to intervene arguing, among other reasons, the privacy of the home. The health system has also been slow to respond. An effective response to violence must be multi-sectoral; addressing the immediate practical needs of women

The chapter on Violence Against Women (VAW) in the Beijing Platform for Action states that "The absence of adequate sex-disaggregated data and statistics on the incidence of violence make the elaboration of programmes and monitoring of changes difficult" (para 120).

Moreover, it recommends, among other things, the promotion of "research and data collection on the prevalence of different forms of violence against women, especially domestic violence, and research into the causes, the nature and the consequences of violence against women and the effectiveness of measures implemented to prevent and redress violence against women" (para 129 a).

Beijing Platform for Action, 1995

experiencing abuse; providing long-term follow-up and assistance; and focusing on changing those cultural norms, attitudes and legal provisions that promote the acceptance of and even encourage violence against women, and undermine women's enjoyment of their full human rights and freedoms. For this, the health sector must work with all other sectors including education, legal and judicial, and social services.

Background on WHO's work on Violence Against Women

In 1995 the Women's Health and Development programme in WHO (WHD), with its many partners, identified violence against women as a priority area. In February 1996, WHD held the first WHO Consultation on Violence Against Women. This meeting brought together women's health advocates, researchers and service providers working in the field of VAW to review existing knowledge of the problem, current and ongoing activities and identify gaps. The recommendations from the meeting served as the basis for the plan of action on violence against women (VAW) developed by WHD. 1996 was spent mobilizing resources and in the preparation work for the activities identified in the plan of action, most of which were initiated in 1997.

The focus has been on building the knowledge base for policy and action and identifying the role of the health sector in the prevention of VAW and in providing care for those experiencing abuse. This responds to the first three objectives of the WHO Plan of Action on violence and health, approved by the Executive Board in January 1997. These are: to describe the problem, to understand the problem, and to identify and evaluate interventions. The work initiated in WHD was relocated to Global Programme on Evidence for Health Policy (GPE) in 1998. In December 2000 it was transferred back to the restructured Department of Gender, Women and Health (GWH). Close links are maintained with the Department of Violence and Injury Prevention (VIP).

Aims and Objectives for VAW

The long term aims of GWH's activities in the area of violence against women are to identify effective strategies to prevent violence, and to decrease morbidity and mortality among women experiencing abuse.

The specific objectives are:

- to increase the available knowledge of the magnitude of the problem and its health consequences and to disseminate it among policy-makers, health providers and programme planners;
- to identify appropriate prevention and intervention strategies that can reduce the prevalence/incidence of violence against women by partners;
- to improve the capacity of health workers at all levels to identify and respond appropriately to women suffering mental/emotional, physical and sexual abuse;
- to support the formulation, by national governments, of adequate anti-violence policies and protocols; and
- to serve as an advocate within WHO and with professional health associations, for greater recognition of the implications of violence against women for health policies, programmes and training.

Activities on Violence Against Women

This report focuses on the activities related to the WHO multi-country Study on Women's Health and Domestic Violence as this remains our largest investment in the field of VAW. We are also involved in several other activities on violence against women, which are briefly described in point 3.

1. Multi-country study on Women's Health and Domestic Violence

WHO initiated the multi-country Study on Women's Health and Domestic Violence in 1997 in response to the recommendations of the Expert Consultation on VAW in 1996 (copies of meeting report available) and of the Beijing Platform for Action. Both identified the need for reliable data as an important factor for enhancing the recognition of the problem among policy-makers and for de identification of effective responses.

The protocol and core questionnaire were the result of extensive consultations and were developed with participation from the country research teams. They were approved by the Scientific and Ethical Review Group (SERG) of the UNDP/UNFPA/WHO/ World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) and by SCRIHS in October 1998. The core questionnaire was subsequently revised, based on discussion of pre-test results with the country research teams. The protocol and the core questionnaire can be made available on request.

1.1. Objectives

Objectives of the Multi-country Study on Women's Health and Domestic Violence

- To obtain reliable estimates of the prevalence of different forms of violence against women in several countries.
- To document the health consequences of domestic violence against women (reproductive health, mental health, injuries, general use of health services).
- To identify risk and protective factors for domestic violence against women, and compare them within and between settings.
- To explore and compare the strategies and services used by women who experience domestic violence.

The Study is also committed to several corollary outcomes, including:

- Developing and testing new instruments for measuring violence cross-culturally.
- Increasing national capacity amongst researchers and women's organizations working on violence.
- Increasing sensitivity to violence among researchers, policy-makers and health providers.
- Ensuring that the results are used for the development of policies and interventions.

1.2. Participating Countries

The study will provide important data on prevalence, determinants and related risk and protective factors and health consequences of VAW from a diverse group of countries: Bangladesh, Brazil, Japan, Namibia, Peru, Samoa, Tanzania and Thailand

Countries included were selected, with the WHO regional offices, on the basis of the following criteria:

a. absence of existing population-based data
b. presence of local anti-violence groups positioned to use the data for advocacy and policy reform
c. presence of strong potential partners known to WHO
d. receptive policy environment that is open to taken up the issue
e. absence of recent war-related conflict
f. regional representation

We will consider having a second stage of the study should funds become available, particularly to include regional representation from the Middle East and Eastern Europe.

1.3. Country study teams

The study has been designed to ensure that both the main and the corollary objectives are achieved. For example, country research teams include at least one women's organisation working with women experiencing violence. In this way we aim to ensure that their experience informs the design and implementation of the research, and that the research results will be used for advocacy and policy change in the countries. The teams are encouraged to set up an in country consultative committee involving a wide range of sectors from both governments and NGOs which will guide the process, ensure political support and also help with the dissemination of the results and their application to the development of policy and interventions.

1.4. Methodology

The quantitative component of the study consists of a cross-sectional population based household survey of 1500 women aged 15 - 49 in both the capital city (or large city) and a representative province. Prevalence estimates for the occurrence of different forms of physical, sexual and psychological violence are obtained by asking female respondents direct questions about whether they have experienced explicit behaviours over specified time frames. Follow-up questions are used to explore whether the violence is ongoing and to identify the perpetrators of different forms of abuse. Women experiencing physical violence are asked about forms and frequency of injury, health care and other support received, and where they would have liked to get more help. All women are asked questions for a reproductive health history and other specific physical symptoms, and for mental distress an internationally validated screening tool (SRQ20) is being used.

A range of complementary qualitative research techniques are also used to help inform the development, interpretation and presentation of the quantitative research findings. These include key informant interviews, focus group discussions with both men and women exploring community attitudes towards violence, and in-depth interviews with survivors of domestic violence.

1.5. Support to country teams from central level

WHO provides strategic and technical oversight to the study through two means. Dr Claudia GarcPa-Moreno has overall responsibility for the study. She is also co-ordinating the input of an expert Steering Committee established to guide the development and implementation of the study. The Steering Committee, consisting of international leaders in the field of violence against women, will meet at least three times over the period of the study. Most recently it met in December 2000. The Committee reviewed progress and made valuable recommendations on analysis and dissemination of the study results.

A Core Technical Assistance Team provides technical support and responds to the needs of the country teams. This includes Ms Lori Heise and Dr Mary Ellsberg from PATH (Washington D.C.), Dr Charlotte Watts, Senior Technical Advisor to the Study from the London School of Hygiene and Tropical Medicine, and Dr Henriette Jansen (WHO), who assists the countries with all aspects of data collection and analysis. An Administrative Officer, Mr Ludy Suryantoro (WHO) is overseeing the financial reporting and contract management with the countries.

Significant progress has been made during the past years on the implementation of the study.

Summary of Progress in 1999/2001

1999

- Second meeting of Research Teams (February): draft questionnaire reviewed extensively on basis of formative research and pre-test results in one country; sampling frames reviewed and agreed; plans for pre-testing and next stages agreed.
- Core questionnaire reviewed to incorporate suggestions from country research teams.
- "Putting Women's Safety First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women" printed and disseminated.
- Pre-testing of revised questionnaire (draft 4) in 5 study countries.
- Third meeting of research teams held in London (July): reviewed and reached consensus on the questionnaire revision based on the pre-test results from five countries and discussed next stages for the training guidelines.
- Further improvement of content, lay-out and coding of questionnaire
- Preparation of field manuals, data entry screens and data entry and cleaning procedures started.

2000

- Questionnaire and manual with detailed question by question explanation finalized.
- Field manuals finalized: Facilitator's manual (and accompanying materials), supervisor and field editor manual, and interviewer manual.
- Data entry system and data processing manual completed.
- Training and data collection completed in Brazil, Japan, Peru, Thailand and Samoa.
- Formative research, translation, and testing underway in Bangladesh, Namibia and Tanzania.
- Collaboration initiated with the National Women's Institute (SERNAM) in Chile to adapt methodology for a survey in Chile.
- Ongoing communication with country teams regarding budgets, study team, sampling, research design, selection of second site and planning next stages.

- Preparation of data analysis plan and outline for preliminary report initiated.
- Second Meeting of Expert Steering Committee (4-6 December): reviewed progress of study implementation and agreed on recommendations for: analysis and interpretation, authorship, dissemination of materials and use of questionnaire by third parties, advocacy and dissemination of findings, and plans for secondary analysis and for validation of survey instrument.

2001 (upto May)

- Fourth Meeting of Research Teams held in Geneva (10-14 January): sharing of lessons learned, update from all countries, brainstorm on advocacy and information dissemination strategies at local, national and international levels, and planning for next stages, including discussion of plan for analysis and preparation of preliminary reports for countries that have completed data collection.
- Presentation of WHO Study methodologies at Fourth meeting of the International Network of Researchers on VAW in South Africa on exploring qualitative and quantitative approaches to capturing women's experiences of sexual violence.
- Continue development of data analysis plan, re-coding and syntax programmes.
- Revision and publication of "Putting Women's Safety First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women".

Upcoming in 2001

- Data analysis and preliminary reports from: Thailand, Brazil, Peru and Japan.
- Training and data collection in Bangladesh, Tanzania and Namibia.
- Recruitment of a communications officer and development of an advocacy and information dissemination plan.

1.6. Impact of the study

The study has already engaged a wide range of actors in the countries where it is being implemented. In addition to providing valuable information for use by countries and internationally, the study has already had an impact at many levels. Annex provides examples of preliminary data from countries. In the box follow examples of this at the country level.

Examples of impact of the study at country level

Peru

- In Lima and Cusco the study has involved a group of around 100 professional women who have acquired a high level of interest in the topic and are now committed to working on violence against women and be replicating agents for this information.
- The level of knowledge and interest in violence against women has increased in academic spaces, particularly in the University where the study is located. VAW is now even being incorporated in several curricula, such as the masters on reproductive health and sexuality.

- The project has had a high level of interaction with the existing services in Cusco and Lima, including health services, which has allowed development of up-to-date directories of existing services for women, joining networks and developing services where there are gaps.
- In the department of Cusco the teams have worked closely with local authorities (municipal, health, police, etc) in 3 provinces: Anta, Canas and Espinar, sensitizing them to the problem of violence against women and gender issues.
- Information materials on violence against women and available services have been developed and distributed to women participating in the study and to many others.

Brazil

- Inclusion of the theme on the political agenda of the Ministry of Health for example by being incorporated as a new subject in the programmes of family health and of women's health and by establishing a taskforce on violence against women.
- The study team, has been involved in a number of training courses for health personnel to include the theme of domestic and sexual violence against women.
- Impacts in the University: Involvement of master and doctoral students form the faculty of Medicine and the faculty of Social Sciences in the study, inclusion of the theme in graduate programme of Medicine, participation in ethical research committee of the Centre of Health Sciences of the Federal University of Pernambuco.
- Educational material produced for the study: directory of services for women, guide for health professionals, other educational materials are in preparation.
- The NGO SOS Corpo has as a result of being involved with the study increased its involvement in partnerships for political interventions on regional level, in particular with other NGOs and the legal sector; increased demand for individual services by women in violent situations.

Thailand

- The institutions responsible for implementation of the project, the Institute for Population and Social research (IPSR), Mahidol University and the Foundation for Women (FFW), have established networks with related organizations and researchers working in the area of violence against women.
- Both IPSR and FFW have become a source of information for local organizations needing information on violence against women.
- A rich collection of information about violence against women collected in the course of the project enables IPSR to share the information with students and participants attending various study programs at IPSR.
- The careful research design for this study has helped the team at IPSR to strengthen their skills in data collection. The fieldwork lessons learned have been documented and a report in Thai will be written to give detailed information about fieldwork experiences. The ethical consideration used in this study will be a useful guideline for other (social science) studies conducted about sensitive issues, where in the past such considerations were often ignored.

2. Development of research methodologies and other materials for research on violence against women

As attention and concern around VAW has mounted, many more researchers and donors have become interested in pursuing work in this field. This new-found interest, while positive, leaves substantial room for costly methodological mistakes, breaches of ethical standards and other actions that may put women at risk of harm. In recognition of the need for practical and ethical guidance on how to conduct such research, the Study Team has developed various tools:

2.1. "Putting Women's Safety First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women"

This document was first printed in 1998. It has been widely disseminated, both in paper and electronic formats. It has recently been revised and the new version is now available. It also exists in French and Spanish.

Ethical and Safety Recommendations for Research on VAW

Research on domestic VAW raises important ethical, safety, methodological and interviewer training issues, but experience shows that:

- It can be conducted will full respect of ethical and safety considerations.
- When interviewed in a sensitive and non-judgmental manner in an appropriate setting, many women will discuss their experiences of violence.

The following are examples of actions that will help ensure that women are not put at risk during the process of data collection:

- The safety of the respondents and the research team is paramount, and should infuse all project decisions.
- Prevalence studies need to be methodologically sound and build upon current experience about how to minimize under-reporting of abuse.
- Ensuring confidentiality is essential to both women's safety and data quality.
- The study design must include actions aimed at reducing any possible distress caused to the participants by the research.
- All research team members should receive specialised training and on-going psychological support.
- Researchers and donors have an ethical obligation to help ensure that their findings are properly interpreted and used to advance policy and intervention development.

2.2. " Researching Violence Against Women: A Practical Guide for Researchers and Advocates "

WHO has been providing support to the development and testing of a manual for conducting research on VAW by Women's Health Exchange (main authors currently at PATH). The manual aims to capture the collective wisdom of the members of the International Research Network on Violence Against Women (IRNVAW) undertaking community surveys in

resource poor settings and lessons learned in the development of the WHO Study. The manual is being edited and will be finalised and published this year. A draft for review is available.

2.3. Protocol and core questionnaire of WHO Study

Apart from being used in the WHO Study, the protocol and survey instrument are further being shared with researchers and institutions who have expressed an interest in doing similar research on VAW. They have already been used in Indonesia and Chile. Collaboration has also been established with other researchers that may use parts of the questionnaire to explore links between VAW and health outcomes such as studies on HIV/AIDS in Tanzania and mental health problems in Ethiopia.

3. Other activities on violence against women

GWH has developed other activities on violence against women, in addition to the Multi-country Study. Many of these are undertaken in close collaboration with the new department of Violence and Injury Prevention (VIP). These are described below:

3.1. Sexual violence research initiative (with the Global Forum for Health Research)

WHO participated in organizing a consultation on Sexual Violence Research, with the Global Forum for Health Research and others. The meeting was hosted by the Key Centre for Women's Health of the University of Melbourne, Australia, in May. It aimed to map out what was already being done, identify gaps and develop a future research agenda. The meeting led to the development of a closed list-serve discussion, run by WHO, to discuss the development of an international initiative on sexual violence. A steering committee, chaired by Dr C Garcia-Moreno of WHO, is providing guidance to the development of this ongoing initiative. The group is in the process of defining a research agenda, and a first meeting was held in South Africa in February by some members of the group to discuss measurement of sexual violence.

3.2. Meeting on 'VAW and HIV/AIDS: setting the research agenda' (with RHR and VIP for the third day on rape and post-exposure prophylaxis.)

This meeting took place in Geneva from 23-25 October 2000, with funding from UNAIDS. It brought together experts to:

- Discuss current activity in this area
- Identify research questions related to the interactions between domestic and sexual violence and IV/HIV/AIDS in different regions and among different age and population groups
- Identify opportunities to integrate issues of violence into ongoing HIV/AIDS research activities and vice versa
- Discuss methodological, ethical and safety issues associated with conducting research in this area, including provision of post-exposure prophylaxis to rape survivors, and
- Make recommendations/proposals for a research agenda to address violence against women and HIV/AIDS.

A report of the meeting is available. It includes recommendations related to child abuse, domestic violence, violence related to disclosure of HIV status and around testing, and

trafficking for sex and sex workers. Specific recommendations were made to WHO, which need to be discussed further with other departments in WHO and UNAIDS.

3.3. Meeting and development of guidelines for health sector response to sexual violence

This is a joint initiative with the department of Violence and Injury Prevention (VIP). The first step is a meeting to be held in June 2001 to review the needs and constraints for developing an appropriate health sector response to sexual violence in resource poor settings. The meeting will include a thorough analysis of issues related to the gathering and use of medical forensic evidence, with the aim of developing WHO norms and standards in this field.

3.4. Review of donor funding to violence against women, with a focus on community-based interventions.

WHO, with the London School of Hygiene and Tropical Medicine, has initiated a review of what donors are funding in violence against women, with a particular focus on projects to do with: a)research, b) health sector interventions and c) community-based interventions to address violence against women. We will be analysing the responses, in particular reviewing community based responses to vaw. This will feed into a broader review of interventions to respond to violence against women, which WHO will be undertaking.

3.5. International meeting on "the role of the health professional in addressing violence against women"

WHO participated as co-chair of the Scientific Committee in the organizing of this meeting with the Italian Institute of Public Health, the International Federation of Obstetricians and Gynecologists (FIGO). The meeting was held in Naples from 15-18 October 2000. It reveiewed experiences from different countries in responding to violence against women, barriers to addressing this topic, and made recommendations to professional associations of doctors and midwives at international and national levels as well as to inter-governmental organizations, namely WHO and UNFPA.
The proceedings will be published as a special issue of the Journal of Obstetrics and Gynecology.

3.6. Review of health needs of trafficked women

A review of the health needs of trafficked women is being carried out by the LSHTM, in collaboration with WHO. Ethical and safety guidelines for working with women who are trafficked are being developed, building on those produced by the WHO Multi-Country Study. A small consultation is planned and a proposal will be developed to respond to the concerns identified.

WORKPLACE VIOLENCE IN THE HEALTH SECTOR: VIOLATION OF HUMAN AND WORKERS' RIGHTS

Dr. Mireille Kingma

Introduction

Violence - being destructive towards another person - is increasing. According to the World Health Report of 1997, violence in all its forms has increased dramatically worldwide in recent decades. Apart from civil conflict and war, violence can be interpersonal, self-directed, physical, sexual and mental, including acts of exclusion.

Violence is a generic term that incorporates all types of abuse - behaviour that humiliates, degrades or otherwise indicates a lack of respect for the dignity and worth of an individual.

Violence crosses all boundaries, including age, race, socioeconomic status, education, religion, sexual orientation and workplace. A recent report undertaken by the International Labour Organization concludes that workplace violence has also gone global, crossing borders, work settings and occupational groups. Violence has become a public health concern of epidemic proportion with extensive health care ramifications.

The International Labour Organisation as a normative body addressing workplace conditions and protocols has created a network of interrelated occupational health conventions that guarantees workers the right to a safe work environment. Violence in the workplace constitutes a violation of this basic right.

Violence towards health personnel

Health personnel have a particular interest in eliminating violence. As carers, they often have first line contact with the increasing numbers of the victims of violence.

Unfortunately, a small number have also been known to be the aggressors. Patient or colleague abuse clearly violates professional codes of conduct. Recent research emphasizes the interaction of various contributing factors including work environment, conditions of work, and work interrelationships as well as individual behaviour. The specific causative factors need to be identified and eliminated.

Ironically, health personnel are also a major target or victim of violence at the workplace. A recent study concluded that the risk of health care workers experiencing violence is sixteen times greater than it is for other service workers. In Sweden, research highlighted that the health sector accounted for 25% of all the reported incidents of workplace violence. Health care workers are more likely to be attacked at work than prison guards, police officers, transport workers, retail or bank employees.

Violence occurring in the external environment at times invades the personal lives of health personnel. Amnesty International has repeatedly denounced cases where staff have been victimised in countries experiencing armed conflict or under oppressive regimes. Last year, the International Council of Nurses, World Medical Association and the International Pharmaceutical Federation made a joint intervention at the 56th Session of the United Nations High Commission for Human Rights demanding that measures be taken to secure the safety of health personnel providing primary health care and working in conflict zones.

Health personnel also suffer from the societal tolerance of violence. The legal system has on several occasions refused to grant compensation to nurse victims. This was justified on the principle that to practise nursing was to accept the risk of personal violence. Nurses themselves often feel that they are "legitimate targets" and that violence is "part of the job". These attitudes are destructive and must be changed.

Within the health sector, let us look at the statistics:

- Physicians: 63% of a sample of UK GPs had experienced abuse or violence during the pervious twelve months, with approximately 20% having done so at least once per month.
- Ambulance personnel in Australia: 1 in 4 had been attacked on the job in the course of working year.
- Research internationally however has confirmed that within the health sector, nurses are as much as three times more likely to be victims of violence than other categories of health personnel. Female nurses are considered the most vulnerable.

  ⇒ 97% of nurse respondents to a UK survey knew a nurse who had been physically assaulted during the past year.
  ⇒ 72% of nurses don't feel safe from assault in their workplace.
  ⇒ Up to 95% of nurses reported having been bullied at work.
  ⇒ Up to 75% of nurses reported having been subjected to sexual harassment at work.

  ⇒ General patient rooms have replaced psychiatric units at the second most frequent area for assaults.
  ⇒ Patients almost exclusively perpetrate physical assault.

What are some of the contributing factors?

- Working in isolation.
- Inadequate staff coverage, staffing patterns.
- Shift work.
- Highly accessible worksites with poor security measures.
- Lack of staff training.
- Inter-relationships within the work environment, e.g. managers' disinterest.
- Dealing with people who have been drinking or taking drugs, under stress, frustrated, violent or grief-struck.
- Reform leading to downsizing and/or downgrading personnel skill mix.

And what are the consequences of workplace violence?

- Deterioration of the quality of care provided.
- Deterioration of the work environment.
- Abandonment of the profession reducing health services available to the general population.
- Negative effect on recruitment to the health professions.
- Perpetuation of unacceptable societal behaviours.
- Increasing health costs.
- Deterioration of staff health.

A "Zero Tolerance" Campaign

There needs to be a concerted effort to eliminate violence and its negative consequences. A multi-prong ***zero tolerance*** campaign must be introduced and reinforced. The strategies would include:

A. Legislation dealing with workplace security
   1. Safety rules and regulations
   2. Monitoring mechanisms
   3. Implementation measures for improvement
   4. Disciplinary framework

B. Clinical issues
   1. Flagging patient charts highlighting past violent behaviour
   2. Education: identifying autonomic nervous system precursors to violence
   3. Improved containment techniques
   4. Safe staffing levels

C. Organisational climate
   1. Policies sending the right messages: Zero tolerance
      a. Staff
      b. Patients, relatives, etc.
   2. Adequate patient flow management
   3. Support structures, e.g. privacy, counselling services

D. Physical environment
   1. Safe access
   2. Security measures
   3. Interior design, e.g. rooms, visitor transit, furniture

E. Staff competence in dealing with violence
   1. Knowledge
   2. Skills
   3. Attitude

Conclusions

Violence in society is an increasing problem of already epidemic proportions. Health care workers, especially nursing personnel, are recognized as being at higher personal risk of abuse and violence in the workplace.

Society has responded in various ways to incidents of violence and with varying degrees of success. Violence in the health sector is highly destructive and has a negative impact not only on the professional and personal lives of health care workers but also on the quality and coverage of care provided.

Workplace violence is a violation of human and workers' rights and cannot be tolerated. Nurses are committed partners in the campaign against workplace violence.

For more information and references, please refer to ICN (1999) ***Guidelines on Coping with Violence in the Workplace***. Geneva: International Council of Nurses, 3, Place Jean-Marteau, CH 1201 Geneva or visit www.icn.ch.

TRADITIONAL VIOLENCE AGAINST GIRLS

Mrs. Berhane Ras-Work

Violence against women and girls is built in as a value and norm in the patriarchal system, which prevails worldwide. The unequal and unjust power and economic relationships between men and women, puts most women in a vulnerable position that forces them to submit to different forms of violence in silence and abject apathy.

Wife battering, in many countries, is considered as an expression of love on the part of the husband. The violence exercised by a husband on his young virgin wife the first night of marriage is welcomed as an honour to the family of the girl. **Raping** women during conflicts and wars is a demonstration of power and domination in many different regions where conflicts reign. **Bride burning** is commonly practised in India, as is **female infanticide** in China, which until recently was in part due to the one child policy. **Widowhood rites** as practised in certain African countries such as Nigeria and Burkina Faso do not allow widows to eat, sleep or wash. Widows are suspected of witchcraft and are chased out of their villages. Economically, they become so vulnerable that they submit to be inherited by the deceased husband's brother or other relative.

Malnutrition

In many societies, **son preference** leads to neglect of the girl child with severe discrimination in nutrition, health care and education. In families where food is scarce, the most nutritious food is preserved for boys. World Health Organisation (WHO) reports low nutritional status of girls and women in developing countries, particularly in Africa. Food taboos, which prohibit women and girls from eating essential foods, result in serious nutritional deficiencies among millions of girls and women.

Malnutrition, including anaemia, among girls and women is a serious health problem, especially in Africa. In 1985, WHO reported that caloric consumption was 16% less for girls under the age of five than for boys. From the end of the first month to the end of the first year of life, the death rate of female infants is 21% higher than for males.

Childhood Marriages

In many African and Asian countries, childhood marriages still occur. Girls as young as 8 years old, and often between 9 to 12 years old, are given away to husbands. By early puberty, they are already pregnant. Such very young mothers have not completed their own physical, emotional, or intellectual growth. Competition for scarce nutrients produces nutritional deficiencies in both the mother and the baby.

WHO reports over 50% of the first births in many developing countries are by women under the age of 19.
Many reasons are given to justify and explain why the practice of early marriages persists. Protection of the virginity of the girl for the honour of the family is a primary one. Another common reason is to enlarge kinship relations for economic reasons.

Female Genital Mutilation

Female genital mutilation (FGM), also known as female circumcision, involves cutting away part or all of the female genital organs. However, circumcision is not an adequate description, as removal of the clitoris is comparable to removal of the penis, not merely the foreskin. Thus, the more accurate term, female genital mutilation, is gradually replacing the much milder and rather misleading term, female circumcision.

According to WHO, more than 100 million women and girls in more than 24 countries have undergone female genital mutilation. According to UNICEF, an estimated 1 to 2 million girls are subjected to this highly harmful practice every year.

The procedure usually is performed under very unhygienic conditions, without any anaesthesia. An untrained elderly woman uses razor blades, pieces of glass or knives. In many countries, the same women are traditional birth attendants (TBAs) and traditional healers. In Mali, Nigeria, Sierra Leone, FGM is an income generating activity. In Sudan, Somalia, Djibouti and Nigeria, some mothers take their daughters to clinics to have the procedure done under medical supervision. This is known as the "medicalization" of FGM. In remote nomadic areas where a "professional" exciser is not available, grandmothers or aunts operate on the girls. In some communities, barbers routinely do the FGM.

The short-term consequences of FGM include severe physical pain, infections, bleeding, and many deaths. The long-term consequences are chronic physical and psychological complications, including exposure to and contraction of HIV/AIDS.

Age

The age at which a girl undergoes the practice varies from region to region, and within the same country from community to community. For example, in Ethiopia among the highland population, a baby girl's genitals are mutilated when she is 7 days old. Among the lowlanders near the Somali border, girls are infibulated at age 6 or 7.
In West African countries where FGM is performed as an initiation rite, the age range varies from 13 up to the time of marriage or childbirth. Among the Ibos in Nigeria, excision is done just before marriage. In mid-Western Nigeria, the Abohs excise a woman just before her first child is born.

Types of female genital mutilation

To date, eight major types of female genital mutilation have been identified and documented: sunna, clitoridectomy, excision, infibulation, defibulation, re-infibulation, the Gishiri cut and Angurya cut.

Sunna: Although 'sunna' means purification according to the Islamic religion, in this context it implies the removal of the prepuce of the clitoris. Incisions are made in the prepuce of the clitoris without removing it totally.

Clitoridectomy: is the total removal of the clitoris. "The midwife punctures the clitoris to expose it to the maximum. Then the clitoris is rubbed until it stands erect, after which it is pulled and chopped off with a blade or a knife."

Excision: is the total removal of the clitoris and the labia minora.

Infibulation: is the removal of the clitoris, the labia minora and the labia majora. The two sides of the vulva are then stitched closed, only leaving a small opening for urination and menstruation..

Defibulation: is performed on brides just prior to intercourse to open the vagina. It is also done to expectant mothers during labor to enlarge the passage scarred from infibulation. In either case, anaesthesia and hygienic precautions are rarely used.

Re-infibulation: is done to young mothers after delivery and to wives during a long absence of their husbands. Again, anaesthesia and sanitation are rare.

Gishiri cut: This is an operation performed by a traditional birth attendant (TBA) on women with prolonged labour. The TBA uses a knife to cut through the soft tissues for the purpose of enlarging the passage of the birth canal. Many infections, fistulas, and deaths are reported as complications.

Angurya cut: This is an operation performed on female infants to remove the hymen loop due to a superstition that it will continue to grow and seal the vaginal orifice.

Geographical Distribution of Female Genital Mutilation

FGM currently is practiced in the following countries:

Excision: Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Sudan, Tanzania, Togo, Uganda, Yemen.

Sunna: The above countries plus Australia, Bahrain, parts of India, Indonesia, Malaysia, and United Arab Emirates.

Infibulation: Djibouti, Egypt, Ethiopia, Mali, Somalia, Sudan.

Gishiri and Angurya cuts: Nigeria.

FGM is also reported to exist in Europe among the immigrant populations in Denmark, England, Finland, France, Germany, Italy, the Netherlands, and Sweden. The origin and cultural background of each immigrant family dictates the types of operations performed.

The Reasons Advanced For The Persistence Of Female Genital Mutilation

The reasons for the continuation of FGM vary according to the socio-cultural context.

The major justifications are:

- Religious or moral
- Virginity: family honour
- Economic: bride price
- Aesthetic
- Social integration
- Hygiene
- Prevention of Child Mortality

Religious

High-ranking Islamic and Christian religious leaders have stated that neither the Koran nor the Bible oblige women to go through the operation. The origin of the practice predates Islam and Christianity. FGM existed in its current geographical distribution well before the spread of either religion.

Religion is the most frequent reason advanced for the practice of FGM. Those who practise FGM usually believe that Islam makes the practice obligatory. It does not. Christianity is also cited as a justification. It is not. Most women in the countries where FGM exists believe that as good Moslems or good Christians they must go through the ritual of FGM.

Aesthetic reasons and social integration

Among some communities, it is believed that the genital organs of a young uncircumcised girl gives her the semblance of a man. At birth, every individual is supposed to be endowed with a male and female soul, which affects the organs of procreation. The female soul of a man is located in the foreskin while the male soul of the woman is located in the clitoris. To be integrated into the society, the man should lose his foreskin through circumcision and the woman should lose her clitoris through excision.

The young uncircumcised girl is still considered today as "impure," and as a second-class citizen. Such a girl can neither marry nor even be allowed to prepare the family meal until she submits to be circumcised.

The practice is inculcated in the minds of the girls throughout their socializing process by family members and peer groups. In Sierra Leone and many other countries, FGM forms part of the initiation ceremony to womanhood. After the operation, the girls undergo training on how to be good wives and mothers.

The initiation that takes place in the Sande bush is kept as a binding secret among the initiates who form a secret society. An uninitiated girl is neither considered eligible for marriage nor is she accepted by her community. She becomes an outcast and is not allowed to engage in any kind of business.

The reasons commonly advanced for maintaining FGM do not have any legitimate religious or scientific basis. FGM does not reduce promiscuity, much less guarantee virginity. It does not ensure fertility. It can cause sterility due to resulting infections. It

is a leading cause of complications during childbirth. Ignorance is a major factor in the persistence of the practice. Some parents subject their children to FGM with the best of intentions. The low economic and educational status of women prevents them from having access to essential information. Most African countries lack strong government policies and actions to eradicate the custom.

Benefits To Excisers

Excisers are respected among their societies as skilled traditional surgeons, herbalists, and traditional birth attendants. They are paid in cash and in kind. They enjoy high social status. The eradication of FGM entails the deprivation of these practitioners from their income and status. In order to effectively campaign against the practice, alternative sources of income have to be found for this group.

History of Female Genital Mutilation

The origin and history of FGM are eclipsed by the passage of time and several speculations are advanced with regard to its origin. Shandal, in his 1963 study of 'Circumcision and infibulation of females', states that "a large number of circumcised females were found among the mummies of ancient Egyptians, but few infibulations were encountered'. It is also believed that FGM was performed on Egyptian women to mark a class distinction. Dr. A.H. Taba wrote that "in the fifth century BC, female circumcision was practised by the Phoenicians, Hetites and Ethiopians as well as by the Egyptians. This practice was transported from Egypt to the Sudan, the Horn of Africa and moved along the Sahel belt with the migration of the population."

Progressive Efforts Made To Eradicate Female Genital Mutilation

World Health Organization

The first major step taken to deal with FGM was the 1979 Khartoum Seminar on Traditional Practices, organized by the WHO Regional Office for the Eastern Mediterranean (EMRO). At the meeting, FGM was extensively discussed and specific policy recommendations were made for its progressive eradication. WHO/EMRO recommended that WHO adopt an FGM policy and recommended the establishment of national commissions to coordinate FGM eradication activities including legislation, public education, and sensitisation of midwives and traditional birth attendants (TBAs).

In 1982, WHO issued a statement recognising FGM as having serious health consequences. The recommendations made at the Khartoum meeting were re-emphasized and WHO expressed its readiness to support national efforts aimed at eradicating the practice. Health workers were strongly advised not to perform FGM under any conditions. WHO/EMRO adopted a resolution at its 35th session, stating that women's health must be safeguarded by ensuring the elimination of harmful traditional practices.

In 1989, the WHO Regional Committee for Africa (AFRO) unanimously adopted a resolution recommending that each country adopt appropriate policies and strategies to eliminate FGM.

In 1989, the final declaration of the Safe Motherhood Conference in Niamey, sponsored by WHO, UNFPA, UNICEF, and the World Bank, called for the eradication of FGM and other harmful traditional practices.

In 1992, at the WHO Technical Discussion on Women, Health and Development a proposal was made stating that more courageous steps must be taken by the national and international communities to eliminate mutilating practices.

UNICEF

UNICEF co-sponsored a Regional Seminar on Traditional Practices, held in Dakar in 1984. It provides financial, moral and technical assistance to the Inter-African Committee and its national affiliates. It gave financial support for research on traditional practices undertaken in Burkina Faso, Chad, Ethiopia, Niger and Sudan. It also finances activities such as seminars and workshops in Benin, Ethiopia, Sierra Leone and Uganda. The UNICEF Executive Board paper E/ICEF)1992/L.5 confirms the UNICEF policy regarding the genital mutilation of children.

UN and NGO Forum

In 1980, at the Copenhagen Conference on Women's Decade, the subject of female circumcision was raised before an international audience. At the NGO Forum, held parallel to the conference, concerned Western women discussed and condemned the practice as a barbaric custom. Africans regarded this interference as Western cultural imperialism and reacted to it negatively.

The actual conference document on the revision and evaluation of progress achieved, doc. A/CONF.94/9, refers to the subject of FGM in the sub-heading "Cultural practices affecting women's health".

The Second UN/ECA (Economic Commission for Africa) Regional Conference on the Integration of Women, held at Lusaka, Zambia, 3-7 December 1979, condemned sexual mutilation but called on a cautious approach to the international campaign. It called upon Africans to find suitable solutions to the problem.

Female Genital Mutilation at the UN/Human Rights Centre

FGM was first introduced by NGOs to the Working Group on Slavery and Slavery Like Practices, in 1981.

On 13 March 1984, the Commission on Human Rights, by its resolution 1984/48, recommended the setting up a special Working Group of experts on traditional practices and ECOSOC endorsed the recommendation by its resolution 1984/34 May 23,1984. The Working Group held its first session 18-25 March 1985 in the presence of several NGOs to study the practice of FGM, and related issues such as the preference for the male child and traditional birthing practices.

The Working Group concluded that FGM is a complex problem and has an evolutionary aspect. The Group called on governments to adopt policies and legislative measures for its eradication. It also recommended educational measures to be taken and requested governments to support local efforts being made by

individuals and organizations. It recommended the organization of international, regional and national meetings for exchange of information. The report of the Working Group, doc. E/CN.4/1986/42, was presented to the UN Commission on Human Rights at its 42nd session. The Commission, by its resolution E/CN.4/1986, requested the relevant specialized agencies of the UN system and interested NGOs to provide assistance to the governments in their efforts to fight harmful traditional practices.

A Regional Seminar on Traditional Practices was also organized by the UN Human Rights Centre in Burkina Faso in 199 and in Sri Lanka in 1994. The recommendations made at these two seminars formed the basis for a plan of action drawn by the special rapporteur to be adopted by the Sub-Commission on Prevention of Discrimination and Protection of Minorities.

National and Regional instruments

The 1990s marked the decade where concrete legislative measures were taken by African governments. At present the following countries have specific laws against FGM: Burkina Faso (1995), Djibouti (1995), Ethiopia (in the Constitution), Egypt (Ministerial Decree, 1997), Ghana (1994), Guinea (1985), Ivory Coast (1997), Senegal (1999), Tanzania (1998), Togo (1998). It is hoped that all other concerned governments will follow this example and enact specific laws against FGM and other such practices.

In Europe, Denmark, England, France, Sweden and Switzerland there are laws prohibiting FGM. On the level of the European Union, discussions are underway on the enactment of a common law against FGM covering all European countries.

The African Charter on the Rights and Welfare of the Child also protects children from harmful traditional practices.

The Abuja Declaration: The UN Economic Commission for Africa (ECA) organized a conference in Abuja, Nigeria, in November 1989, to review the 'Role of Women in Africa in the 1990s'. Among other issues, traditional practices such as early marriage and pregnancy, female circumcision, nutritional taboos were discussed and proposals for action were made. The proposal calls for research, training, dissemination of information and legislation to eradicate harmful traditional practices. The setting up of a sub-regional structure was also recommended for the follow-up.

The Fourth World Conference on Women, held in Beijing in September 1995, witnessed the international awareness about violence against women in general and FGM in particular. Several statements were made by high level officials, including the Secretary-General of the United Nations, and delegates called for the elimination of FGM as a gender based violence.

Concrete Actions To Stop The Practice

As more and more public awareness developed, organizations were formed with the aim of eradicating FGM. In 1977, the NGO Working Group on Traditional Practices was set up in Geneva with a membership of international organizations enjoying

consultative status with the UN Economic and Social Council. The Group was assigned to undertake missions to several African countries to study the extent of the problem and to hold dialogue with nationals on the best approach to adopt in handling the problem. Its efforts resulted in the initiation of educational activities in Burkina Faso, Egypt, Kenya, Mali and Sudan.

The Group has also been lobbying at various meetings such as the World Health Assembly, the UNICEF Boar meetings, the sessions of the Commission on Human Rights, and the Commission on the Status of Women. Members of the Group made statements, submitted communiqués and appealed to governments to take action. Briefing sessions with African delegates were held during the WHO Assembly in 1983 and 1984 at the request of members of the Working Group. Members of the Group took an active part during the two sessions of the UN Working Group on Traditional Practices held in 1986.

During the drafting of the Convention on the Rights of the Child, it was the NGOs that lobbied for the inclusion of article 24.3 calling upon the States Parties to protect children from practices prejudicial to their health.

In 1984, the Working Group, in collaboration with the Government of Senegal, WHO, UNFPA and UNICEF organized a Regional Seminar in Dakar, that was attended by representatives from 20 African. A unanimous agreement was reached to eradicate harmful traditional practices and to follow this decision by establishing the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children.

The Working Group continues its campaign against FGM through advocacy and fundraising. WHO and UNICEF participate in its activities with an observer status.

Inter-African Committee

The Inter-African Committee (IAC) is a regional body set up in 1984 with the following mandate:

- to reduce the morbidity and mortality rates of women and children through the eradication of harmful traditional practices,
- to promote traditional practices that are beneficial to the health of women and children,
- to play an advocacy role, by raising the importance of taking action against harmful traditional practices at international, regional and national levels,
- to raise funds and support local activities of national committees and other partners.

Since its creation, IAC has set up national committees in the following 26 countries: Benin, Burkina Faso, Cameroon, Chad, Congo, Côte d'Ivoire, Djibouti, Egypt, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Tanzania, Togo and Uganda.

In the African context, the fight against FGM had to take into consideration several challenges:

- the huge number of women affected (over 120 million),
- the status of the affected women: social, economic, political, and level of education,
- the influence of society,
- varying cultural contexts,
- the different actors, i.e. excisers, mothers, grandmothers, fathers, etc.
- opinion leaders,
- political settings, i.e. the relationship between governments and citizens,
- financial means for operations.

Many obstacles had to be faced and ways and means had to be identified to deal with FGM effectively. The experience of IAC over the last 16 years reveals that challenging and dealing with long standing social beliefs and behaviours necessitates carefully tailored strategies for effective and result-oriented intervention. The main programmes are:

Training and Information Campaign (TIC): TIC training workshops are aimed at providing intensive and meaningful health education with the help of visual aids. The subjects discussed are related to FGM, early marriage, human reproduction, pregnancy, childbirth, breastfeeding and hygiene as well as to nutritional taboos. The programme consists of 4 sets of training workshops, to be conducted consecutively in 5 months. After each TIC programme, 28 persons will have been trained to be able to conduct sensitisation programmes on the harmful effects of FGM and other traditional practices, and a further 136 persons will have attended workshops to spread information regarding these issues.

Training of Traditional Birth Attendants (TBA): As TBAs can play an important role in the campaign against harmful traditional practices, it is necessary to provide them with an effective training programme and to encourage them to campaign for the abolition of FGM and other such practices.

For IAC, the aim of the TBA training is first to train head trainers for a short period and to ensure that the required information pertaining to the practice is transmitted to other TBAs working in rural areas and mother in the communities. First, a head trainer gives a one-day training for five future trainers. Each will in turn train 50 TBAs in rural areas, thus creating a multiplying effect. When each TBA programme is completed, 50 TBAs wils have been trained to play a key role in rural areas in the campaign against FGM and other harmful traditional practices.

Alternative Employment Opportunities (AEO): The campaign against FGM has to include changing the attitudes of practitioners and finding them alternative sources of income for their livelihood.

IAC has run two pilot AEO projects for excisers, one in Ethiopia and another in Sierra Leone. In both projects, a selected number of women have identified income generating activities such as baking (Ethiopia) and tie-and-dye (Sierra Leone), and are working in groups running their projects. Members of these groups have abandoned

the practice of FGM and are used as agents of change within the communities. At present, similar projects are being implemented in several African countries.

Research: IAC conducts research projects in the area of traditional practices, particularly FGM. Several research papers are produced showing the extent of the problem. These documents are valuable, particularly for designing strategies of intervention.

Production of educational materials: IAC produces and distributes a number of educational materials to be used in the different programmes of education and information such anatomical models, flannelgraphs supported by slide presentations. There are also Multi-media training modules and materials targeted specifically to reach four major groups: women in influential positions and those participating in activities of women's organizations; secondary school students and youth groups, both male and female; teachers, religious and community leaders and paramedical staff. The modules include transparencies, slides, cassettes and stories with pictures.

The IAC video (Beliefs and Misbeliefs) (43 min.) explains the dangers of FGM and shows the activities of IAC in Africa. A French version is also available.IAC. is currently in the process of making a new film which will show results obtained and constraints met during the last 16 years.

Regional meetings

In view of the need for concrete legislative measures against FGM and other harmful traditional practices, IAC organized its first Symposium for Legislators, in September 1997 in Addis Ababa. The outcome of this meeting was the Addis Ababa Declaration, which recommends that all concerned governments enact specific laws prohibiting FGM and other such practices. The Addis Ababa Declaration was submitted to the OAU for study and adoption, and in June 1998 the OAU Council of Ministers unanimously adopted the Declaration. This decision was endorsed by the OAU Assembly of Heads of State and Government.

In 1998 in Banjul, IAC organized a Symposium for Religious Leaders, with the aim of examining the religious justifications for the practice of FGM. High level religious scholars, both Moslem and Christian, studied relevant texts in the Koran and the Bible and in the Banjul Declaration, issued at the end of the Symposium, they unanimously stated that there is no religious justification for the continuation of FGM and that religious leaders in all concerned countries should set up a network with the objective of spreading the message. In August 2000, a Follow-up Symposium for Religious Leaders was organized in Arusha, Tanzania, to assess the results of the first symposium and to examine strategies for the future.

In November 1999, IAC organized a Follow-up Symposium for Legislators to elaborate a Draft Convention on the Elimination of All Forms of Harmful Traditional Practices Affecting the Fundamental Rights of Women and Girls. A group of legal experts gathered to formulate the draft which was then presented to the Symposium for study and amendments. At the end of the symposium, the Draft Convention was adopted for submission to the OAU.

After careful examination by OAU legal experts, it was suggested that the Draft Convention be integrated into the OAU Draft Protocol to the African Charter on Human and Peoples' Rights, on the Rights of Women. The adoption of this Draft Protocol will take place in the near future.

IAC organizes regional conferences every 3 year to examine the problem of FGM, to elaborate new strategies and to work out activity plans. The last regional conference took place in Dar-es-Salaam, Tanzania, 27 February-3 March 2001.

Youth are a very important target group in the campaign for the eradication of FGM and other harmful traditional practices. With this in mind, IAC organized a Forum for Youth Empowerment in April 2000 in Addis Ababa. More than 60 youth (girls and boys) from 16 African countries took part in the meeting. After 3 days of intensive discussions and debates, including training workshops, the delegates issued an African Youth Declaration on Harmful Traditional Practices, which among other things proposes a plan of action and the creation of an African youth network, in order to carry out activities among peer groups.

Conclusion

Harmful traditional practices, as forms of violence against women, exist in contexts where women have no or little education about the functions of their body and are unaware of their fundamental rights to health and well-being. Women living in rural traditional settings have low economic status with marriage as the only guarantee for survival. Traditionally condoned sanctions are applied rigorously to control the productive and reproductive role of women. FGM and other such practices are clear examples of such control mechanisms.

In order to eradicate such practices, which hamper the normal development of the girl child and seriously affects the health of women, education is a vital element. The education of the girl child is bound to enhance her knowledge and her value. Formal, informal and non-formal education should be intensified to reach opinion leaders, women, men and policy makers to ensure change of attitudes. Policies that favour the advancement of women are also indispensable as a backing for grassroots activities and general social mobilization.

ALCOHOL AND VIOLENCE

Mr. Hans Rüttimann

The problem area "Violence" has many manifestations. Sadly the close connection with alcohol is rarely, if ever mentioned. For example, alcohol plays a large part in the following circumstances:

- road accidents
- offences
- accidents at work and in the home
- mistreated children
- conjugal violence
- sexual crimes and acts of violence
- the transmission of Aids
- violence in sports stadiums
- arson

This list is not exhaustive and it concerns addicted and non-addicted people. As a reference, I would like to state, very simply, what is mean by an addicted and non-addicted person. An addicted person is one who can not control the quantity he/she drinks. On the other hand, a non-addicted person is one who usually drinks moderately, but when e.g. the said person has caused a traffic accident, he/she has drunk too much.

For a general discussion it is important to mention that many factors such as loss of working hours, higher hospital costs and bad planning and errors in production, heavily burden the economy and the state, and the income from taxes from the sale of alcohol cannot make up for this economic loss.

For the purpose of illustration and clarification we note some statistics:

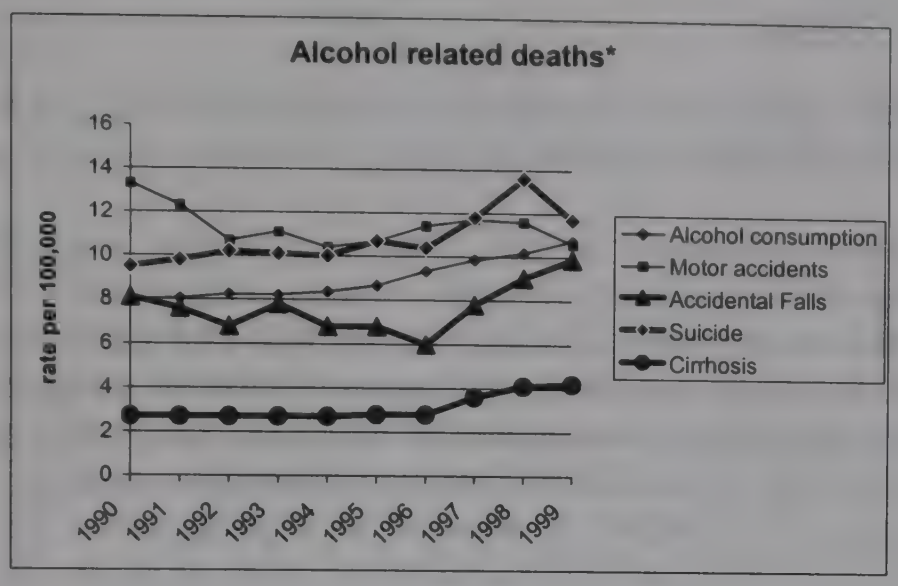
England *(From our sister organisation Hope UK, 25 (F) Copperfield St. GB-SE1 0EN London, Tel. 0044 020 7928 0848, Fax 0044 020 7401 3477, www.hopeuk.org)*

Alcohol use is deeply embedded in our culture and sensible drinking campaigns have done little to reduce alcohol-related harm. Some of the latest figures show that:

- 41% of violent crimes, including assaults and muggings, were committed by people who had been drinking.
- Between 60 - 70% of men who assaulted their partners were under the influence of alcohol.

- Heavy drinking was associated with 15% of drownings.
- 23% of calls to child helplines involved alcohol-related neglect.
- Drink was a factor in 65% of suicide attempts.
- 40% of 13 and 14 year olds were drunk or stoned when they first experienced sexual intercourse.

Ireland



Alcohol-related Problems *	1995	1996	1997	1998	1999
Public order offences	10'209	16'384	25'755	27'945	31'488
Liquor Law Offences	16'689	12'642	16'110	15'690	13'072
Drink driving offences	4949	5975	7616	8707	9570
Drunkeness	3124	2066	2038	1747	1970
Assaults	7375	7811	8191	8802	9471
Liquor offences/under 18 yrs	183	206	542	291	398

Economic Cost of Alcohol Related problems

Alcohol related:	*(Source: S Byrne*, 2001)*
Healthcare costs	£220 m
Road accidents	248 m
Crime	79 m
Absences from Work	736 m
Transfer payments	342 m
Lost taxes re lost output	100 m
TOTAL	**£1.722 billion**

** Source: Alcohol and Ireland: A myth becoming reality by Dr. Ann Hope, Department of Health & Children, Ireland*

Composition of Social Costs – Netherlands **		
Social Costs of excessive consumption	**1996** KPMG BEA	**2001** KMG BEA
Case & Treatment of Addictions	64m	149m
Genera Health Care	45m	253m
Work	1815m	3424m
Crimes and Offenses	272m	1854m
Total	2196m	5680

** *Source: Excessive Alcohol Consumption in the Netherlands:Trends and Social Costs, KPMG-Bureau voor Economische Argumentatie, February 2001. For more information: www.kpmg.nl/bea*

The Blue Cross an International Federation, in more than 45 countries, suggests that an **Alcohol Awareness Campaign** be held annually in every country. This should be run under the same heading throughout the world. The theme for 1999 was "Alcohol and Violence". The topics should be repeated after five years, repeatedly. For more information please contact the International Federation of the Blue Cross, Lindenrain 5a, P.O. Box 6813, CH-3001 Bern, Switzerland. Tel: +031.300.5860, Fax: 031.300.5869 Email: ifbc.bern@bluewin.ch

OVERCOMING THE VIOLENCE OF SILENCE

Dr. Elizabeth L. Bowen

I would like to start with a story. The idea of the title was to use this story as an opportunity to talk about. I have found that around the world one of the simplest ways is to tell stories of children and experiences of children, and I was very happy when Peter Newell and some others did so this afternoon. I would like to share a true story of two seven year olds in Israel, an area of the world that is struggling with violence and trying to find peace. These two seven year olds were on their way to the first day of school and the Israeli girl said to another girl whose father was from Jamaica and mother was from Iraq, "Are you one of the chosen people." And the little girl whose father was from Jamaica and mother from Iraq said, " I don't know but I'll ask my dad and I'll tell you tomorrow," and the girl from Israel said, I don't think you are one of the chosen people," and the other seven year old said, "Why not?" The other girl said, "Because your skin is too dark." The seven year old stood up to her full height, about a meter, said, "No, I don't know the answer to that. God doesn't care about my skin, he wants me to have a clean heart, and I'm very sorry but I'm afraid your heart has a little dirt on it." So there she was being a peacemaker, deflecting the prejudice or discrimination that the other girl was sending in her direction but also defending herself and reaching a hand in friendship to try to help this other little girl understand that the color of her skin didn't matter, she would still be her friend.

That's the type of way we can begin to overcome the violence of silence and particularly to equip children with language so they can have a vocabulary and the emotional literacy to explain these situations and to be able to solve them in a nonviolent way. As world citizens we have a responsibility to overcome the violence of silence. If you ask, What is responsibility? the big scenario says that it is the ability to respond, and I was very pleased this morning when Dr. Krug opened with a definition of violence, because I think one of our challenges, particularly in the international context, is to define what are we talking about. What is violence?

And if you ask the next question of those of us in the room who are in the field of health, what is health, what is *your* definition of health, we see that the World Health Organization's (WHOs) current definition is not merely the absence of disease or infirmity but is also the presence of physical, mental, and social health. The point I want to make is that we might also want to add freedom of violence to that definition. The dictionary simply defines health as freedom from disease. After hearing this, I'm thinking perhaps it should also say freedom from violence.

If you look at the root of the word "health," it means wholeness, oneness, unity, and many cultures believe that a sense of oneness and harmony is the basis of spiritual health and

happiness. So many people say it's hard to have mental health if you are not happy. There is quite an interplay of these definitions, to try to bring the two great traditions of humanity, that is, science and religion, science will tell you that health is a balance of the constituent elements of the physical body; religion will tell you that health is a sense of well being and a sense of oneness and unity with humanity and with a creed.

So we need to find a way of having a dialog that includes these elements. In looking at the World Health Assembly resolution I found that in 1984 the Assembly said, "We understand the spiritual dimension to imply a phenomenon that is not material in nature but belongs to the realm of ideas, beliefs, values, and ethics that have arisen in the minds and conscience of human beings, and we invite member states to consider including in their strategies for health a spiritual dimension." Defining "spiritual" in that sense as ideas, beliefs, values, and ethics, and our speaker from Africa just now brought that out, we really need to look carefully at the culture, at the definition, at the values, at the beliefs, at the stakeholders, in order to unravel the causes and begin to work toward the solutions.

In May of 1997, the NGO Forum for Health was invited to participate in WHO's Formal Consultation with a review of the progress of a WHO Renewal Strategy and the "Health for All by the Year 2000." Several NGO representatives spoke compellingly of the need to expand the WHO definition of health to encompass spiritual health as well as social, mental, and physical health.

On January 22,1998, the WHO Executive Committee proposed to insert "Health is the dynamic state of complete physical, mental, spiritual, and social well being and not merely the absence of disease or infirmity." So my understanding is that the necessary next step is for the World Health Assembly to agree to include that sentence in the constitution as an amendment, a redefinition. I hope the NGO Committee will be very active toward this end, because I believe it is going to be very difficult to solve this violence problem without having such language to use as instruments.

The World Bank recently held a meeting where they requested papers on valuing spirituality and development. They realize we can't have true human development without addressing the issues of the spirit. And this paper requested by the World Bank on how it is that we can develop spiritual indicators such as equality of men and women, such as full consultation so that everyone has a voice. Here this paper mentions the concept of spirituality and spiritual values, once almost taboo in most UN development related deliberations, now being articulated at the highest level. Why? Because we are beginning to realize some of the answers reside in those realms, in the realm of ideas. Even the greatest scientists such as Albert Einstein said that peace cannot be kept by force, peace can only be achieved by understanding. And I want to give tribute to Dr. Ram and others on the Steering Committee of the NGO Forum about what an instrumental role, I believe, this Forum is playing in creating a climate in which these ideas can be shared and discussed

I would like to suggest that the NGO Forum consider dedicating its next symposium to the theme of the spiritual dimensions of health to see what we could do to bring this in line with public health policy, with research and practice, and to find where are the best practices and the practical solutions that do bring this matter into the open.

You might go further and ask, what is peace? In the same way that health is more than the absence of disease, peace is more than the end to war. United States Senator Jeanette Rankin wrote that winning a war is like winning an earthquake. To reduce violence we need to study peace, in individuals and families. There is more war in homes than there is on battlefields. Therefore we really need to study what is a peaceful family. How do we have a violence-free family? I would like to propose a definition that, in essence, peace stems from an inner state, supported by a spiritual or moral attitude, and it is chiefly in invoking this attitude that enduring solutions can be found. So if we can agree that peace is possible; that to have a peaceful home is possible, a peaceful neighborhood is possible, it is possible to have a peaceful nation, to have a peaceful world, then we can perhaps say that if peace is possible, perhaps peace is also inevitable, and then we can move from there, then how do we get from here to there in a strategic sense? I was very touched by Dr. Professor Peter Newell's statement that it's a child's right not only to not experience violence but also not to witness violence. And you think how far we are from a world where a child would not even witness violence.

Perhaps we need to go even farther and ask ourselves what is a child? As a Baha'i, my idea of a child is that a child is a mine rich in gems of inestimable value. So when I see a child I wonder if that child will find the cure to AIDS. I wonder if that child will sign the final peace that will make war socially unacceptable. I wonder if that child will participate in dismantling apartheid. I wonder about each child's potential and what would be the way that the world can benefit from that.

Similarly, I would like to review very briefly what this Forum has done in the past five years to overcome the violence of silence. Last year the focus was on Breaking the Grip of Poverty. Gandhi wrote that poverty was the worst form of violence. Mother Theresa wrote that it's far more difficult to overcome spiritual than material poverty, yet both conditions must be addressed systematically. There must be keys to both. And regarding poverty we might bring a medical analogy something like malnutrition, only that malnutrition puts a person on the brink of illness because they don't have the necessary resistance to withstand life-threatening diseases. Similarly, poverty puts society on the brink of war.

Poverty is a cause of war. Few societies deal effectively with poverty and to limit extreme poverty, the solutions require a combination of moral and practical approaches. One is to call attention to basic rights, which is something this Forum, I think, can be proud of in its presentation to the World Health Assembly after its session on Globalization in 1998. The Forum said we must take a rights-based approach and implement fully the United Nations' human rights instruments as they relate to health, for example, the Universal Declaration of Human Rights, the Convention on the Rights of the Child, the Convention on the Elimination of Discrimination Against Women, and the Covenant on Social, Economic, and Cultural Rights. Those will be instruments that will help to make poverty socially unacceptable. Some may believe the poor will always be with us. Some might believe that is a symbol that is not really meant literally. Some believe that eventually humanity will have a minimum standard of sustenance in order to uphold human dignity.

Few societies have dealt effectively with poverty. To eliminate extreme poverty, effective solutions require the combined application of moral, spiritual, and practical approaches. Calling

attention to basic human rights, and identifying spiritual principles, such as the principle of justice, facilitate the discovery and implementation of practical solutions, and accelerate the process of lifting individuals, communities and nations out of poverty.

I wanted to show also that current thought on this is that we shouldn't be talking about alleviation of poverty, we should be talking about eradication, that poverty should be as socially unacceptable and morally unconscionable as slavery. Similarly, when we hear talk about female genital mutilation; we haven't heard anything about alleviation, we've heard about elimination. And I think we can try to accelerate the process at which these things happen.

I also wanted to share an analogy about tobacco which was a theme at this conference two years ago, in 1999, the Tobacco-Free Initiative. This consensus that the way we can solve that is to reduce demand for tobacco, reduction of demand particularly among young people, so that it will be so socially unacceptable that few people will take up the habit.

Similarly, I think that NGO's can begin to mobilize public opinion on how do we reduce demand for child prostitution. UNICEF estimates that about a million children a year are sold into prostitution. We have very little discussion about how is it that we can reach people so that they will not seek out the child prostitute. These, I think, are more fundamental questions and I think we need all kinds of approaches, but I think this is part of the violence of silence. We need to ask who is going to those prostitutes and why, and ask why is there so much war in the home and how can it be prevented at that level.

I wanted to share one story that I've heard from a woman pediatrician from Sierra Leone. She asked me to share this story of a seven-year-old girl who came to her clinic. She held up her right arm and she said, "Will my hand grow back by my next birthday?" The hand had been cut off by a soldier. And by sharing this story, I hope we will all be inspired to do some soul searching as to what we can do as individuals and as the NGO Forum for Health, to prevent violence and also to prevent war, so that that won't happen to any other girl or to any one else, and not be tolerated at any level.

For example, many people have mentioned that girls suffer the most from the violence of silence. The denial of gender equality perpetrates an injustice against half of the human race, against half of the world's population, and promotes in men harmful attitudes and practices that are carried from the family to workplace and ultimately to international relations. We have to, therefore, apply the "lens" of perspective in all aspects of our work because we know that only as women are welcomed into full partnership in all fields of human endeavor will the moral and psychological climate in which international peace can emerge, can violence be greatly reduced if not eliminated.

In 1997, the NGO Forum for Health Symposium theme was "Health for All Means Women and Men." Women and girls probably suffer the most from the violence of silence. The denial of gender equality perpetrates an injustice against one half of the world's population and promotes in men harmful attitudes and habits that are carried from the family to the workplace and ultimately to international relations. For instance, seventy percent of those in poverty are women and girls. Women and girls are exposed disproportionately to domestic violence, prostitution,

trafficking, and numerous other profound hazards to their physical, mental, social and spiritual health. We must apply the "lens" of a gender perspective in all aspects of our work. Only as women are welcomed into full partnership in all fields of human endeavor will the moral and psychological climate be created in which international peace can emerge and violence decrease.

So in closing, I wanted to share a couple of quotations. One is from the founder of the Baha'i Faith, Baha'u'llah, who said justice is the best beloved of all things in God's sight, and he went on to say that justice is the basis of peace and we can't have peace until we have justice because we can't leave half of humanity in a condition of injustice and expect there to be peace in the families, and so forth. His son, Abdul Baha'i, said we should strive to look at everyone as a member of our own family. He said regard each person as your mother, or your father, or your sister, or your brother, or your child. He said if you can attain to this, your difficulties will vanish, you will know what to do. Many times when we deal with issues of violence–and the violence of silence – belong in the realm of ideas, beliefs, values and ethics. If we can bring it to the level of the family and the community, we can begin to find working solutions that will help us to solve these problems.

I wholeheartedly encourage each one of us to focus on ways that we, as public health professionals, can apply universal spiritual principles as we seek to develop effective instruments to promote world health and world peace.

RESPONSES FROM THE FLOOR

GENDER BASED VIOLENCE

Ms. Claire Hoffman
International Planned Parenthood Federation

Male Involvement
It is crucial to involve men in addressing violence against women to work to prevent a destructive polarization between women and men. For example, International Planned Parenthood Federation's (IPPF) affiliate member Family Planning Association in Sweden have set up crisis centres for men who are the perpetrators of violence. The perpetrator is confronted by male staff about his violent behaviour providing staff with personal insights to the staff and assisting them in teaching new ways to relate to women and resolve couple conflicts.

Follow-up studies have shown that about 50 percent of the men who make use of the center have been able to stop their harmful actions.

Legal Advice
IPPF's affiliate in Venezuela has successfully integrated services to deal with victims of gender-based violence providing them with counseling, medical, psychological and legal attention. This holistic approach involves training of existing staff, advocacy for legislation on domestic violence within Congress, motivating the clinic personnel to offer integral services to women and collaborating with other NGOs to open up the debate on gender-based violence.

Men in Authority
When addressing issues of gender-based violence we also have to consider that often the perpetrators are men in positions of authority and power – and thereby much harder to be brought to account. This would include, for example, the police, military and teachers who abuse their position. There are, for example, all-women police stations in some countries such as India, but they are only at the moment a 'drop in the ocean'.

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VIOLENCE AGAINST WOMEN

Ms. Gudrun Haupter
International Alliance Of Women

Brigitte-Pross Memorial Seminar in Ouagadougou, Burkina Faso, March 16-18 2001

The theme of the programme centred on 'Strategies of Education and Mobilisation of Women and Men for the Gradual Abolition of Violence Against Women (VAW) and Girls in Burkina Faso. One of the recommendations at the programme suggested the creation of a national structure in June 2001 to coordinate the NGOs' and Associations' activities on Violence against Women. The objective of this body would be to activate, exchange and disseminate experiences and to mobilise resources.

The participants were divided into various thematic groups dealing with specific issues:

- traditional harmful practices
- new harmful practices e.g. sexual harrassment
- social exclusion
- domestic violence
- violation of reproductive rights.

The needs identified by the various groups at the seminar included:

- Moral and technical support from IAW, such as providing documents.
- Funding for translation into vernacular languages.
- Capapcity building through training and awareness raising activities.

Speeches were made on the various types of VAW and the strategies used in Burkina Faso to combat the phenomena, on violence and underenrollment of girls, legal protection of women against violence, existing laws and the difficulties of their application . In addition, particular experiences regarding strategies and actions were described by several organisations, among them PromoFemmes, a member organisation of the Fédération des Femmes Burkinabé. Many of the problems and strategies sounded very familiar to us but case studies highlighted specific hardships like taking away all property from widows despite existing legislation and, the practice of female genital mutilation (FGM).Two video films were also shown, on girls' exploitation as street vendors and on FGM, with testimonies from all those concerned.

The seminar was organised jointly by PromoFemmes and RECIF/ONG and was attended by 75 participants. The IAW was represented by Board members and individual members and a message from President Patricia Giles was read at the opening ceremony. Tribute was paid to the memory of Brigitte Pross for her many activities in support of women worldwide and especially for those of Burkina Faso.

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WORLD ASSOCIATION OF GIRL GUIDES AND GIRL SCOUTS

Ms. Lili Schürch

World Association of Girl Guides and Girl Scouts (WAGGGS) has embarked on a project on HIV/AIDS, in partnership with International Council of AIDS Service Organisations (ICASO) and the UNAIDS. The project provides a curriculum on HIV/AIDS for girls and young women, and a training kit for leaders. This was initiated in response to the widespread feeling that women and youth bear a large share of the burden of AIDS throughout the world and need information on how to protect themselves. The project hopes to gives a chance to those affected to benefit from the advice of professional health workers, who for their part will be able to spread education on through counselling and community projects.

WAGGGS has also launched a campaign on the prevention of early adolescent pregnancies, focusing on young women under the age of 15. According to WAGGGS, 17 million babies are born to adolescent mothers each year and 60,000 adolescents die from health problems related to early pregnancy. Adolescent pregnancy is a global issue and the key to its prevention lies in education including non-formal education. Through this campaign, WAGGGS hopes to spread awareness and create by providing training kits to leaders working in this area. The training kit has been created in association with the World Health Organisation.

Kits for both the projects can be ordered from the headquarters in London at The Guide Association, 17-19 Buckingham Palace Road, London SW1W OPT. For further information please visit the website: www.wagggsworld.org or e-mail at: wagggs@wagggsworld.org

DECADE TO OVERCOME VIOLENCE

Dr. Manoj Kurian
World Council of Churches

Decade to Overcome Violence (2001 – 2010)

After a couple of years of elaborate discussions and intense preparations, the Decade to Overcome Violence, (DOV) (2001 - 2010) was formally launched in Berlin, Germany on February 4, 2001 by the Central Committee of the World Council of Churches. The World Council of Churches, founded in 1948, is a fellowship of 342 churches in over 100 countries. In launching the DOV, the message to the churches said:

> At this critical juncture in history, we launch the Decade to Overcome Violence: Churches Seeking Reconciliation and Peace as an urgent call to churches and ecumenical organisations:

- To be and build communities of peace in diversity, founded on truth.
- To repent together for our complicity in violence.
- To work together for peace, justice and reconciliation as a visible sign of the churches' unity in life and witness.
- To analyse different forms of violence and their interconnection.
- To engage in theological reflection to overcome the spirit, logic and practice of violence.
- To work to break the cycles of violence.
- To embrace creative approaches to peace building within the Christian tradition, local communities, secular movements, and other living faiths.
- To lead the churches to life affirming and transforming action.
- To stand alongside victims of violence and to seek to empower those people who are systematically oppressed by violence.
- To act in solidarity with those who struggle for justice, peace and the integrity of creation.

The Central Committee at a special plenary on the DOV identified some important issues for further reflection and action at various levels. Some of them were: theological reflection on violence and non-violence, the ecclesiological implications of overcoming violence, the dilemma of violence as a last resort, structural forms of violence, violence against women, the production and sale of small arms, the consequences of war, interfaith approaches to peace building, etc. They also deliberated upon their role in the DOV process and made personal commitments to it.

Several regional, national and church level launches and events have also taken place around this global event in Berlin. Prominent among them were:

- the Asian launch in Melang, Indonesia in November 2000. It was a joint event of the Muslim and Christian organisations with focus on communal harmony;

- the Latin American launch in Baranquila, Columbia in January 2001. It focussed on the plight of children in all situations of violence;

- the East African (Fecclaha) launch in Kampala, Uganda in March 2001 with its focus on economic exploitation as a main cause of violence in the region;

- the American launch in Nashville in April 2001 which marked the culmination of the "Lenten fasting from violence";

- and the West African launch in Accra, Ghana in May 2001 focussing on the issues of small arms and economic bondage.

Besides this, there have also been a number of national and church level launches and events in Germany, Denmark, Norway, Italy, Switzerland, England, Scotland, etc. and many more are being planned to take place during this year.

Issues such as economically instituted violence, economic polarisation as a source of violence, the assertion of identities in an increasingly pluralistic world, the production and proliferation of small arms and weapons of mass destruction, violence against women, religious fundamentalism, racism and xenophobia, the role of media in promoting the culture of violence, etc., are some of the common issues which these events highlighted. There have also been attempts to reflect upon the implications of the DOV for the ecclesial life of the churches and their commitment to the cause of building peace based on justice.

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Visit www.wcc-coe.org/wcc/dov/index-e.html for news on Decade to Overcome Violence

BUSINESS SESSION
NGO FORUM FOR HEALTH
President's Annual Report
Dr. Eric Ram, President
14 May 2001

Ladies and Gentlemen,

It is, once again, a great pleasure for me to report to you a summary of activities of the NGO Forum for Health for the period of May 2000 to April 2001.

In May 2000, in conjunction with the Annual General Meeting, we organized a very successful symposium, the theme of which was: Breaking the Grip of Poverty on Health. This was jointly sponsored by Dept. of Health in Sustainable Development/World Health Organization, Life University and the NGO Forum for Health. This coincided with the UN General Assembly Special Session on Social Development held in Geneva in June 2000. The General Assembly in its Special Session considered a number of initiatives to make the Copenhagen Commitments for 1995 a reality in achieving the overall goals of the World Summit, one of which is to eradicate poverty.

A number of our members of the NGO Forum for Health participated in this event and several of us organized and conducted workshops and seminars on poverty and health related issues, as a part of the Geneva 2000 Forum. All in all it was a very fruitful exercise.

The speakers for the AGM Forum included Dr. Kim Williams (Life University), Dr. David Werner (Healthwrights), Dr. John Martin (WHO), Dr. Mira Shiva (VHAI) India, Dr. Gustavo Parajon (Nicaragua) and Ms. Miriam Maluwa (UNAIDS).

Dr. Elizabeth Bowen of Health for Humanity was our conference rapporteur, and I wish to thank her for her excellent help in putting together the report.

Rules of Procedures

On May 15, 2000 at the Palais des Nations in Geneva, the AGM adopted the "rules of procedure". It took us two years to complete the consultative process but thanks to the hard work of our Steering Committee and a number of you, the members, resulted in its adoption and printing of the "blue book". The "rules of procedure" are now operative.

The Steering Committee

The Steering Committee of the Forum met twice over the year to plan and guide Forum's activities.

Two new members were coopted: Dr. Alvero Bermajo (IFRC) to replace Dr. AliReza Mahalatti (IFCR) and Ms. Anne Lindsay (International Association for Counseling) to replace Ms. Marybeth Morsink (CUI).

It was the decision of this Steering Committee to organize this year's symposium around the theme of Violence and Health.

Cooperation with World Health Organization

The NGO Forum for Health and WHO/NMH jointly organized a meeting on January 9, 2001, which was held at the World Council of Churches. The purpose of this meeting was to strengthen ongoing collaboration between NGOs and WHO, and to provide an opportunity for briefing and discussion on upcoming items on the WHO Executive Board agenda. A good number of NGOs participated in this meeting.

The NGOs welcomed this joint initiative and hoped that it will become a regular feature. The NGOs made a call for the change in the nature of the relationship between WHO and the NGOs, to be more inclusive, to modify the procedure of entering into official relations, space for more active participation in the WHA and Executive Board. Dr. Derek Yach was commended for his willingness to work with the NGOs in the areas of FCTC, Mental Health and Health Promotion, etc. We hope that other Cluster will follow suite

Following the first successful meeting the second collaborative meeting between WHO and NGO Forum for Health took place on April 25, 2001, held at the World Council of Churches.

The purpose of this joint meeting was to have the opportunity to update developments on:
(i). The work in progress in relation to the International Negotiating Body for the FCTC, and
(ii.) Emerging challenges to the prevention of non-communicable diseases.

Two outside speakers were invited. Dr. Ravi Narayan, of Community Health Cell, India gave his perspectives on World Trend and Challenges in Health and spoke about Peoples' Health Charter. PHA is based on principles of: Health is a human right; universal and comprehensive PHC; governments have the fundamental responsibility to ensure universal access to quality health care; people's participation in their own health; and, health has broader determinants including economic, social, physical, environment and political. Professor Iraj Abedian of University of Cape Town, S.A. spoke on Macroeconomic Stability and World Health. He emphasized: a) maximize equitability of access; 2) ensure market competitiveness; c) establish accountability and transparency frameworks; d) promote sustainability of health status, and e) manage the attendant risks.

Global Health Watch

Thanks to Ms. Asmita Naik, our external consultant, the report of the feasibility study on the Global Health Watch project has now been submitted, thus completing the initial two phases envisaged in its plan.

Global Health Watch is one of the major initiatives of the NGO Forum for Health, the aim of which is to act as an independent and credible monitor of equalities in health status of different populations, and to promote a more even distribution of resources to ensure equal health rights for all.

This report incorporates comprehensive reports produced by Community Health Cell and Afri-CAN following their regional meetings on the Global Health Watch held in India and

Zimbabwe respectively, as well as the workshop held on this topic during AGM/WHA in May 1999 in Geneva.

In writing this report, Ms. Asmita Naik also drew on the earlier work of Adrea Mach, the previous consultant.

These initiatives have reviewed:

- Why a Global Health Watch is needed
- How would it function - basic functions; focus; activities, topics; methodology (data, partners, benchmark, etc.); organizations
- What commitments have been made by governments and international organizations on health
- What other NGOs are doing in the area of health and human rights;
- What information exists that could be useful to a Global Health Watch.

Some of the key recommendations are as under:

- Although the two envisaged stages of the feasibility study have been completed, more work needs to be done to establish whether the GHW is a useful and viable proposal. Considerable discussion on the concept of a GHW has now taken place. The project should now move from an abstract to a concrete level.

- As the tangible issues and work required relate to specific country situations, it is proposed that one country be selected for a pilot phase. Given the deep interest and excellent capacities shown by our Indian partners, it is proposed that they should be approached regarding a pilot project. The pilot project could include developing local links and networks; and producing a sample report on health rights and inequalities in India. A realistic and feasible pilot proposal, perhaps concentrating on one state, will need to be developed, given the size of the country.

- At the same time, efforts to stimulate interest in the Global Health Watch in other regions should continue. As a parallel measure, efforts should be made to hold meetings in other regions. It is proposed that initiatives should be pursued in Eastern Europe, Western Europe, Africa, North and South America. There should also be some follow-up to the meeting in Zimbabwe.

- Work to further develop the GHW concept should be continued by the NGO Forum for Health. Particular issues which still need to be explored include for example: how and where the issues identified by the GHW could be presented to the international community - for example, how they could feed into the human rights treaty bodies; details of data available at international level; how the GHW idea fits in with ongoing work at WHO and other organizations.

- There is a need to approach funding agencies for the next phase including the proposed pilot phase in India and further meetings in other regions.

The Steering Committee will review these recommendations carefully and then will take appropriate future steps and directions to take this project to the next level.

Administrative Support

In the NGO Forum for Health we are greatly blessed to have some excellent people who have helped with the work of the Forum this year by volunteering their valuable services. I wish to, therefore, express on behalf of all of us, our many thanks to Ms. Lynn Gorrell and Ms. Elizabeth Forest who helped last year and Ms. Gauri Khanna-Reidhead, who is currently helping us by providing administrative support to the Forum. Gauri is an economist who has recently moved to Geneva with her husband.

Let me especially acknowledge the professional services of a chartered account provided to us by Ms. Anouk Dunne, free of cost, in both maintaining accounts of the Forum and in auditing the accounts. And, to Ms. Asmita Naik, our consultant for the Global Health Project, who has so patiently worked with us and encouraged different regions in conducting the feasibility study and putting together the Global Health Watch report.

Also, let me add a word of appreciation to all the Steering Committee members for their diligent work, cooperation and guidance they have provided me. Thank you.

Respectfully submitted.

Eric R. Ram, Ph.D.
President

TREASURER'S REPORT

Dr. Manoj Kurian
Treasurer

BALANCE SHEET January to December 2000

Swiss Francs

ASSETS		
UBS Account "General Operations"	12,641.65	
UBS Account "Global Health Watch"	15,090.39	
TOTAL ASSETS	**27,732.04**	
LIABILITIES		
Surplus brought forward	37,013.24	
Accounts Payable	1,461.70	
Deficit per Dec. 31, 2000 - Gen. Operations	-8,276.30	
Deficit per Dec. 31, 2000 - GHW	-2,466.60	-10,742.90
TOTAL LIABILITIES	**27,732.04**	

PROFIT & LOSS STATEMENT FY 2000

Swiss Francs

	2000	1998/99
CONTRIBUTIONS - General Operations		
Benefactor	6,754.00	5,866.00
Founding Members	2,500.00	9,905.00
Sponsoring Member	0.00	1,600.00
Supporting Member	800.00	800.00
Contributing Members	870.95	1,709.55
Regular Members	7,753.35	9,165.95
Individual Members	300.00	613.50
TOTAL INCOME - Gen. Operations	**18,978.30**	**29,660.00**
EXPENDITURE - General Operations		
Expenses Volunteers	6,000.00	5,752.70
Expenses Speakers	13,586.60	2,484.00
Postage	1,525.30	1,646.90
Printing Brochures	4,637.20	
Supplies/Conf. exp.	1,343.75	96.00
UBS charges (net)	161.75	224.15
TOTAL EXPENDITURE - Gen. Operations	**27,254.60**	**10,203.75**
Surplus (deficit) end of year	**-8,276.30**	**19,456.25**

CONTRIBUTIONS GLOBAL HEALTH WATCH		
TOTAL INCOME - Global Health Watch	**0.00**	**43,102.79**
EXPENDITURE - Global Health Watch		
Fees Consultants	2,500.00	14,700.00
Participation Conferences		
in Bangalore + Harare		10,820.70
UBS charges (net)	-33.40	25.10
TOTAL EXPENDITURE - Global Health Watch	**2,466.60**	**25,545.80**
Surplus (deficit) end of year	**-2,466.60**	**17,556.99**

CONTRIBUTIONS NGO FORUM FOR HEALTH - General Operations

(Swiss Francs)

	FY1999	FY2000	per 30/04 2001
ADRA EUROPE (PAID BY GENERAL CONFERENCE SDA)	200.00	200 00	
AFRICAN MEDICAL + RESEARCH FOUND.	214.05	266 25	
AGA KHAN FOUNDATION			200 00
AMERICAN INTL. HEALTH ALLIANCE	211 70	253.25	
ASIAN PACIFIC RESOURCE & RESEARCH CENTRE FOR WOMEN	214.05		
BAHA'I INTL. COMMUNITY	200 00		400.00
BOSTON UNIV.SCHOOL OF PUBLIC HEALTH	102.60		
CATH. HEALTH ASS. OF INDIA	216.70		
CENTRE FOR APPLIED STUDIES IN INTL. NEGOT.	200.00	100.00	
CHRISTIAN CHILDREN FUND	200.00		200.00
CHRISTIAN MEDICAL ASS. OF INDIA	214.05	253.25	220.20
CHRISTOFFEL BLINDENMISSION	220.65	216.40	
DAG HAMMARSKJOLD FOUND.	219.95	243.30	
DIFÄM (Deutsches Institut für Ärztliche Mission)	800.00	800.00	1,011.30
FACULTY OF HOMOEOPATHY (British Homeopathic Ass.)		258.65	
FURIC, MARCEL	100.00		
GLOBAL FORUM FOR HEALTH/WHO	200.00	200.00	200.00
GLOBAL HEALTH COUNCIL	454.50		
HANDICAP INTERNATIONAL		200.00	
HEALTH FOR HUMANITY	221.85	253.30	
HEALTH LINK WORLDWIDE	216.70		
HEALTH UNLIMITED	200.00	200.00	190.00
HELEN KELLER INTL.	216.90		252.80
IFRC - A. BERMEJO			200.00
ILEP, LONDON	224.00		
INFACT, BOSTON (anti-tabacco org.)			252.85
INSTITUTE PANAFRICAN DE SANTE	223.35	200.00	245.90
INTERNATIONAL ALLIANCE OF WOMEN			
INTERNATIONAL BABY FOOD ACTION NETWORK		200.00	200.00
INTL. ALLIANCE OF WOMEN	200.00	200.00	
INTL. ART OF LIVING FOUNDATION	200.00		200.00
INTL. CHARITABLE RELIEF ORG.	110.90		
INTL. COUNCIL OF JEWISH WOMEN	200.00	200.00	200.00
INTL. COUNCIL OF WOMEN	200.00	200.00	200.00
INTL. FED. FOR FAMILY HEALTH, INDIA			505.65
INTL. FED. OF BLUE CROSS	200.00	200.00	200.00
INTL. FED. OF BUSINESS & PROF. WOMEN		200.00	200.00
INTL. FED. OF MEDICAL STUDENTS ASS., FERNEY			100.00
INTL. FED. SOCIAL WORKERS	200.00	200.00	
INTL. HOLISTIC HEALTH ASS.	216.70	250.40	252.80
INTL. PLANNED PARENTHOOD			254.10
INTL. SOCIETY OF DOCTORS FOR ENVIRONMENT	200.00		
INTL.UNION AGAINST CANCER	206.45	200.00	200.00
JESUIT REFUGES SERVICE	200.00		
JUNGO, DR. OTTO	100.00	100.00	100.00
L. AMERICAN + CARIB.WOMENS HEALTH NETWORK	214.05		
LA LECHE LEAGUE INTL.	223.40	246.15	
LIFE UNIVERSITY	5,866.00	6,754.00	6,742.00
MED.PROFESSIONALS ALLIANCE, TAIPEI	2,905.00		
MEDICAL ASSISTANCE PROGRAMS INTL.	433.25	470.95	494.55
MEDICAL CARE DEVELOPM. INTL.	227.25		
MEDICAL MISSION SISTERS	205.20	266.25	252.85
MEDICUS MUNDI	200.00	200.00	200.00
NORDIC SCHOOL OF PUBLIC HEALTH	200.00		248.00
NORWEGIAN REFUGEE COUNCIL	205.40		200.00
PAN PACIFIC & SOUTH EAST ASIA WOMEN'S ASS.	200.00	200.00	200.00
PUBLIC SERVICES INTERNATIONAL	421.80	400.00	400.00
RISSHO KOSEI-KAI		200.00	200.00
RITSON, ROBERTA /WHO	100.00		
SIGHT SAVERS INTL.	400.00	400.00	
THE LEPROSY MISSION INTL.	214.05	200.00	200.00
WHO	1,600.00		
WOMAN'S INTL. LEAGUE FOR PEACE & FREEDOM	200.00	200.00	200.00
WOMEN'S WORLD SUMMIT FOUNDATION	100.00	200.00	200.00
WORLD ASS. OF GIRL GUIDES AND GIRL SCOUTS		100.00	250.55
WORLD COUNCIL OF CHURCHES	2,000.00	2,500.00	2,500.00
WORLD FED. OF CHIROPRACTIC		246.15	252.80
WORLD FED. OF MENTAL HEALTH	216.70		
WORLD FED. OF METHODIST UNITING CHURCH W.		200.00	
WORLD HEART FEDERATION			400.00
WORLD ORG. OF SCOUT MOVMT	200.00		
WORLD UNION OF CATHOLIC WOMEN'S ORG.	200.00	200.00	
WORLD VISION INTL.	5,000.00		2,500 00
WORLD YOUNG WOMEN'S CHRISTIAN ASS.	200.00	200.00	200.00
ZONTA INTL.	422.80	200.00	200.00
Total	**29,660.00**	**18,978.30**	**21,826.35**

ELECTION OF OFFICE BEARERS

Dr. Eric Ram, President
Mr. Giovanni Ballerio, Secretary

The election of office bearers was announced in the business session. After serving as the President since 1996, Dr. Eric Ram, the current President announced his intention to relinquish his responsibility as President. It was proposed that the Steering Committee meet to form the Elections Committee and prepare a list of candidates for the office of the President. Nominations would be invited from the Forum's members for this position ,which was deemed crucial for the successful continuation of the NGO Forum for Health. Other office bearers who wish to continue in their present capacity were welcomed to do so.

On behalf of the Steering Committee and the Forum, Giovanni Ballerio, the Secretary, expressed a vote of thanks to Dr. Ram for his devoted service as the President and his life long commitment to making health a reality to all globally.

GLOBAL HEALTH WATCH

Ms. Asmita Naik
Consultant

The Global Health Watch project was initiated in 1998 by the NGO Forum for Health in order to explore how monitoring and advocacy regarding inequalities in access to health care could be improved with the aim of promoting equal health rights for all. Since then a number of initiatives have been carried out to take this idea further in terms of considering the establishment of a Global Health Watch to monitor and report on inequalities in health worldwide. Research has been carried out to see what is already being done in this field by other agencies. Three workshops have also been held, one at the international level, and two at the national level, in India and Zimbabwe. These initiatives have stimulated considerable interest in the idea and have resulted in a deep reflection on the need and functioning of a Global Health Watch. Challenges remaining include taking the project one step further through a pilot study in one country to consider the practical functioning of a Global Health Watch at the national level. In addition, the idea needs to be taken to other regions in order to test its applicability on a truly global scale.

Copies of the Executive Summary of the Global Health Watch Report are available on request from the office of the President of the NGO Forum for Health

ABOUT THE SPEAKERS

Dr. Elizabeth Bowen

Dr. Elizabeth Bowen travels six months per year to promote world health and world peace. She serves as International Liaison for Health for Humanity, an NGO with members in 60 countries. Its mission is to unite people for the advancement of world health.

Dr. Bowen represents the Baha'i International Community on the Governing Board of the World Conference on Religion and Peace. She represented the Baha'i International Community at several United Nations Conferences, including the Population Conference in Cairo, the World Summit for Social Development in Copenhagen, and the World Food Summit in Rome.

In 1993, Dr. Bowen was elected President of Physicians for Social Responsibility, the US affiliate of the International Physicians for the Prevention of Nuclear War, a federation of NGOs that won the Nobel Peace Prize in 1985. After serving on the Board of Directors of PSR for nine years, Dr. Bowen now serves as one of PSR's representatives to the United Nations. PSR's missions are to reduce violence and the causes of violence, to promote environmental health and justice, and to eliminate weapons of mass destruction. For the past four years, Dr. Bowen has served as Rapporteur for the NGO Forum for Health.

Dr. Bowen is based in Atlanta, where she serves on the faculty of Morehouse School of Medicine in the Department of Preventive Medicine and Community Health. She received her Medical Degree from Jefferson Medical College in Philadelphia and her Doctorate in Education from the University of Massachusetts.

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126 Barberry Lane
Peachtree City, Georgia 30269
USA

Ms. Jane Cottingham

Jane Cottingham is Technical Officer for Women's Perspectives and Gender Issues at the Department of Reproductive Health and Research at the World Health Organization in Geneva, a post she has held since 1991. She works with women's health groups, policy-makers and scientists to ensure that women's rights and gender perspectives are integrated into the reproductive health research agenda. She has extensive experience of working with women's rights groups cross-culturally. In 1976 she co-founded ISIS, Women's International Information and Communication Service, and served as the organization's director in Geneva, Switzerland, for 11 years. During this time she helped to create an international women's information network, built up a documentation system on and for women, and co-authored and edited numerous publications on women's issues.

Ms Cottingham received a Masters in Population Sciences from Harvard School of Public Health in 1991. She is a member of the Editorial Advisory Group of *Reproductive Health Matters*.

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11 Av. Appia
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Dr. Mireille Kingma

Dr. Kingma is a Consultant on Nursing and Health Policy with the International Council of Nurses, a federation of over 120 national nurses' associations. She has a Bachelor's Degree in Nursing and post-basic qualifications in Human Resources Development and Health Policy. Her doctoral thesis was on Economic Policy: Incentive or disincentive for community nurses? During the past 16 years, she has been responsible for international consultations and workshop programmes in more than 60 countries. Her current job portfolio includes socio-economic welfare of nurses, human resources development, occupational health and safety, care of the older person, refugees, nursing students, international trade in health services. Previously she worked with the World Young Women's Christian Association and the World Council of Churches.

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International Council of Nurses
3 place Jean-Marteau
CH 1201 Geneva
Switzerland

Dr. Etienne Krug

Dr. Krug was appointed Director of the Department for Violence and Injury Prevention at the World Health Organization in Geneva, Switzerland in October 2000. He is also co-ordinates the development of WHO's first World Report on Violence and Health to be published in 2002. Prior to that, Dr Krug held several positions working on violence and injuries prevention in WHO.

From July 1995 to December 1999 Dr Krug was medical epidemiologist in the Division of Violence Prevention at the US Center for Disease Control and Prevention in Atlanta. During that time he designed, conducted and published epidemiological research focussing on violence prevention at the national and international level. Between 1987 and 1995, Dr Krug worked in war thorn countries for several humanitarian organizations. He served as Medical Doctor in Mozambique and Country Director in Nicaragua and El Salvador for Médecins sans Frontières, as Health and Nutrition Coordinator for the United Nations High Commissioner for Refugees during the Rwandan genocide, and as Human Rights Observer in Haiti.

Dr Krug holds a degree of Medical Doctor from the University of Louvain in Brussels, Belgium and

a Masters Degree in Public Health from Harvard University. He has earned several awards including the 1998 Alexander D. Langmuir and the Paul C. Schnitker Awards from the Centers for Disease Control and Prevention. Dr Krug is editor of several scientific journals and has published many original articles, editorials and chapters. He is fluent in French, English, Dutch, Spanish and Portuguese.

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Prof. Peter Newell

Peter Newell is a long term advocate for and commentator on the human rights of children. He chairs the Children's Rights Alliance for England (NGO coalition). He has coordinated the campaign against corporal punishment of children, both in the UK and internationally. He was Research Coordinator and a member of the Commission on Children and Violence in the UK in 1996 and drafted UNICEF's "information digest" on Children and violence. Together with Rachel Hodgkin he also prepared UNICEF's Implementation Handbook for the Rights of the Child.

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77 Holloway Road
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Mr. Hans Rüttimann

Mr. Ruttiman has been the General Secretary of International Federation of the Blue Cross since 1996. His previous experience has been as a volunteer and a youth worker for the IFBC, and as a high school teacher. He pursued theological studies for lay-people as his area of study.

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Dr. Eric Ram

Dr. Eric Ram is the President of the NGO Forum for Health. He is also the Director of the International Health and International Relations of World Vision International, which is a Christian, humanitarian and development organisation with programmes on 106 countries around the world. He has been a consultant with WHO and UNICEF for a number of years.

Dr. Ram is an internationally known leader in Public Health, who has pioneered the development of earlier primary health care model in Miraj, India. He has studied both in India and USA and has worked at the national and international levels promoting equity and justice in health care. He has traveled to more than 100 countries and has written and published 100 articles and edited several books.

Dr. Ram holds two bachelors degrees, two masters degrees and a Ph.D. in International Health from the University of North Carolina, USA.

Contact details:

World Vision International
6 Chemin de la Tourelle
1209 Geneva
Switzerland

Mrs. Berhane Ras-Work

As the Coordinator of the Geneva based NGO Working Group on Traditional Practices and, since 1984, as the President of the Inter-African Committee, Mrs. Ras-Work has traveled extensively in Africa and other parts of the world to study and assess the situation of women, in particular their human rights in relation to traditional attitudes and practices, and has produced several reports. During her mandate as President of the Inter-African Committee, she has organized several workshops and seminars to train trainers for the promotion of the health status of women. She has also organized regional and international conferences related to the human rights of African women, in collaboration with UNICEF, WHO, OAU and ECA.

Mrs. Ras-Work has played advocacy and lobbied at appropriate meetings, i.e. UN Commission on Human Rights, Committee on the Status of Women, UNICEF and WHO meetings, for the adoption of effective policies against harmful traditional practices, such as female genital mutilation, early marriage, nutritional taboos, etc. She has also served as a resource person in several international meetings and conferences related to the status of women. She took part in the drafting of the Convention on the Rights of the Child and encouraged and supported local initiatives of research on traditional practices in Djibouti, Ethiopia and Senegal.

Mrs. Ras-Work was born in Gonder, Ethiopia, in 1939. Her educational background includes a BA in Education, MA in International Relations and Diplôme d'Etudes de Développement, Institut Universitaire de Développement, Geneva, Switzerland

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For Further Information

The NGO Forum for Health is an inclusive network of multi-sectoral non-governmental organisations who are committed to promoting equity and justice in health care and wish to partner with others in making health a reality for millions around the world.

We invite all NGOs who wish to be a part of this growing influential network both to benefit from and contribute to the work of the NGO Forum for Health.

For further information, please contact either Mr. Ballerio, Dr. Kurian or myself at the addresses below.

Cordially,

Eric Ram
President, NGO Forum for Health

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